

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20530

STATE FILE NUMBER

FILED JUL 8 1957

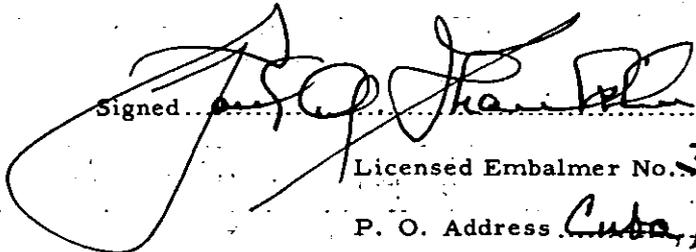
Registration District No. 86 Primary Registration District No. 5322 Registrar's No. 72-1752

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba, Benton Twnsp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cuba, Benton Twnsp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Res. Level Acres, 8yrs</u>		Length of stay in lb	6280 STREET ADDRESS <u>Level Cross Sub Div</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Newton Turnbough</u>			First	Middle	Last
4. DATE OF DEATH <u>June 28, 1957</u>		Month	Day	Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/1897</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Dillard, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ephriam Turnbough</u>			14. MOTHER'S MAIDEN NAME <u>Cornelia Wisdom</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-03-2696</u>	17. INFORMANT <u>Pearl Irene Turnbough, Cuba, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular accident</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____
					DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					420.1
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>MAY 1955</u> to <u>JUNE 1957</u> and last saw <u>her</u> alive on <u>JUNE 28/57</u> Death occurred at <u>4:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. B. Sellings</u> (Degree or title)			22b. ADDRESS <u>Cuba Mo</u>		22c. DATE SIGNED <u>7-2-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/30/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dillard Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Crawford, Dillard, Mo.</u>	
24. FUNERAL DIRECTOR <u>Paul A. Shanklin, Cuba, Missouri</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-3-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 34

P. O. Address Cuba, /

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.