DEC 29 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Washington
Township Harmony
City (No. ..... St. ..... Ward)
Registration District No. 968
Primary Registration District No. 6184
File No. 28962-A
Registered No.

2. FULL NAME Tomas W. Turnbull
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed.
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND~~ OF (OR) ~~WIFE~~ OF Widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 9-1861
7. AGE Years 69 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co
PARENTS
10. NAME OF FATHER William Turnbull
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
14. INFORMANT Robert Turnbough
(Address) Belgrade
15. FILED ....., 19 Fraiola Hohmann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 28 1930
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
200A
Heart failure
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Med Colf - Cemetery
DATE OF BURIAL 8-29 1930
20. UNDERTAKER Sparks & Sparks
ADDRESS Potosi

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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