

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.

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

36055
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE Registration District No. 315
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 740
(c) City SPRINGFIELD (d) Street No. 1125 S. National St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James E. Dulin
(a) Residence, No. 460 S. Grant St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Lillah Dulin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 26, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 11 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired RR Eng.

9. Industry or business in which work was done, as saw mill, bank, etc. On Railroad

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

FATHER 13. NAME Edwin R. Dulin 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

MOTHER 15. MAIDEN NAME Sarah Arty 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Lillah Dulin
Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE Oct. 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Schreyer
Springfield, Mo.

20. FILED Oct 6 1939 Chas A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939 to Oct. 5, 1939
I last saw him alive on Oct. 5, 1939 Death is said to have occurred on the date stated above, at 2:35 p.m.
The principal cause of death and related causes of importance were as follows:
Terminal Bronchial Pneumonia
Date of onset Jan 1

Other contributory causes of importance:
Paralytic Stroke
Art. Hypertension

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____ (Signed) Royce F. Edkins, M. D.
(Address) Springfield, Mo.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X