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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 1 1942

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35061

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 164

1. PLACE OF DEATH  
(a) County Vernon  
(b) City or town Nevada  
(c) Name of hospital or institution 222 S. Pine St.  
(d) Length of stay: In hospital or institution 32 yrs.

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Vernon  
(c) City or town Nevada, Mo.  
(d) Street No. 222 S. Pine St.  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Fannie Walker Dublin  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day 28 year 1942 hour  minute  M.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
7. Birth date of deceased Sept 28, 1857

21. I hereby certify that I attended the deceased from Oct 16, 1942 to Oct 20, 1942  
that I last saw him alive on 10/20/42  
and that death occurred on the date and hour stated above.

8. AGE: Years 85 Months 2 Days 0 If less than one day hr. min.

Immediate cause of death Cerebral Hemorrhage

9. Birthplace Shawanna, Mo.  
10. Usual occupation Yarning

Due to Senile arterio Sclerosis

11. Industry or business   
12. Name Tom Walker  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown

Other conditions   
Major findings of operation Brain Impaction

16. (a) Informant Robert Dublin  
(b) Address Dallas Tex as removed  
(c) Place: burial or cremation Liberty Mo.

Of autopsy   
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)   
(b) Date of occurrence   
(c) Where did injury occur?   
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

17. (a) Signature of funeral director Madal C. Gehrig  
(b) Address Nevada, Mo.  
18. (a) Date received local registrar Oct 30, 1942  
(b) Elizabeth Breckenridge (Registrar's signature)

While at work?   
(Specify type of place) (e) Means of injury   
23. Signature J. M. Yates (M. D. coroner)  
Address Nevada, Mo. Date signed 10/20/42

Yates (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

08  
2

108

2

0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

43

RECEIVED

District Health Officer No. 7,

District File Number 11-42-1224

Date Filed 11-10-42.

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**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..... *Marshall C. Linder* .....  
Licensed Embalmer No. 26576 .....  
P. O. Address. Nevada Mo .....

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35061

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 164

1. PLACE OF DEATH:

(a) County Wagon  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fannie Walker Dulin

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Sept 28 1885  
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days no. (If less than one day \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October 1942 year, hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I saw her \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Breast amputation PHYSICIAN \_\_\_\_\_  
Carcinoma Underline the cause to which death should be charged statistically.  
Of autopsy of breast & 2 yrs ago

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. M. Dulin (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

35061