

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 29774BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 125

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>W. Va.</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN <u>Excelsior Springs Mo. Bdy.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kempton, West Va.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mitchell Clinic & Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>_____</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nina Elizabeth</u>	b. (Middle) <u>Duling</u>	c. (Last) <u>Duling</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 22, 1950</u>
---	---------------------------	-------------------------	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 13, 1888</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u>	IF UNDER 24 HRS. Hours <u>_____</u> Min. <u>_____</u>
-----------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>_____</u>
---	---	--	---

13a. FATHER'S NAME <u>John Kobirshke</u>	13b. MOTHER'S MAIDEN NAME <u>Mollie Dolle</u>	14. NAME OF HUSBAND OR WIFE <u>L. W. Duling</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>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mitchell Clinic Excelsior Springs Mo.</u>	ADDRESS <u>_____</u>
--	-----------------------------------	--	----------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>Several years</u> <u>Several years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute myocarditis</u>	DUE TO (b) <u>Spondylitis</u>	
	DUE TO (c) <u>_____</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Anemia</u>		

19a. DATE OF OPERATION <u>_____</u>	19b. MAJOR FINDINGS OF OPERATION <u>_____</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>_____</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>7221</u>
---	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>_____</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>_____</u>
---	--	---

22. I hereby certify that I attended the deceased from 7/2, 1950, to 9/22, 1950, that I last saw the deceased alive on 9/22, 1950, and that death occurred at 12:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. J. Laughlin</u>	(Degree or title) <u>D. O. W. Mitchell Clinic Excelsior Springs Mo.</u>	23b. ADDRESS <u>_____</u>	23c. DATE SIGNED <u>9/22/50</u>
--------------------------------------	---	---------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Sept 22-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>not known</u>	24d. LOCATION (City, town, or county) (State) <u>Thomas W. Virginia</u>
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>9/22/50</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings Hope</u>	621 25. FUNERAL DIRECTOR'S SIGNATURE <u>Hope Funeral Home</u>	ADDRESS <u>Excelsior Springs Mo.</u>
---	--	---	--------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48241
0



NOV 9 1950

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
Student Embalmer

Signed James A. Moles
Licensed Embalmer No. 3296
P. O. Address Ex Springs, 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.