

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.

30 1930

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

Do not use this space.

Pullard
9813

1. PLACE OF DEATH

County *Pettis*
Township *Sedalia*
City *Sedalia* (No.)

Registration District No. *666*
Primary Registration District No. *5887*

File No.
Registered No. *82* St. Ward)

2. FULL NAME

Frank Durin
(a) Residence No. *R.F.D. No. 1* St. Ward.
(Usual place of abode)

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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 25 1852*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 6 28

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (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) *Ind*

PARENTS

10. NAME OF FATHER *Wm Durin*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *N.Y.*

12. MAIDEN NAME OF MOTHER *Emma Hatch*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Pa.*

14. INFORMANT *Mrs Maude Hering* (Address) *Sedalia Mo*

15. FILED *3-24 1930* *J. B. Love* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 23 1930*

17. I HEREBY CERTIFY, That I attended deceased from *3/20*, 19*30*, to *3/23*, 19*30*, that I last saw him alive on *March 22*, 19*30*, and that death occurred, on the date stated above, at *3:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*valvular insufficiency
929 mitral*

(duration) *2* yrs. mos. ds.
CONTRIBUTOR (SECONDARY) *900* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? *Symptoms*
(Signed) *A. C. Pollard*, M. D.

3/23, 1930 (Address) *Sedalia, Mo.*
*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 *Blair Neb.* DATE OF BURIAL *3-25 1930*

29. UNDERTAKER *Pilluspie* ADDRESS *Sedalia*

