

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.

DEC 10 1938

Registration District No. 792

Primary Registration District No. 4473 6035

Registrar's No. _____

1. PLACE OF DEATH
(a) County Saline
(b) City or town Nelson
(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 _____
In this community Life years, months or days

3. (a) PRINT FULL NAME David Dennis Dundon
3. (b) If veteran, name war ✓
3. (c) Social Security No. _____

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced — ✓
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 18 1885
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 09
If less than one day _____ hr. _____ min.

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

10. Usual occupation Labar

11. Industry or business _____

MOTHER FATHER
12. Name Dundon
18. Birthplace Ill.
14. Maiden name Sarah Kane
15. Birthplace Zuland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Hillen
(b) Address Nelson, Mo
17. (a) Burial (b) Date thereof Nov 29 1938
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Nelson
18. (a) Signature of funeral director Don Short
(b) Address Marshall, Mo.
19. (a) Dec 2 1938 (b) P. L. Lawler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Nelson
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 27
year 1938 hour 4 pm minute _____ M.
21. I hereby certify that I attended the deceased from Nov 27 to Nov 27, 1938.
that I last saw him alive on Nov 27 and that death occurred on the date and hour stated above.
Immediate cause of death Hypertensive Pneumonia
Duration _____
Due to _____
Due to _____
Other conditions Ch. Nephritis
(Include pregnancy within 3 months of death)
Major findings:
Of operations: _____
Of autopsy: _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Marshall (M. D. or other) _____
Address Marshall Mo Date signed 11/29/38

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RECEIVED
District Health Officer No. 8,
District File Number
12/19/39

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 Donald W. Short

Licensed Embalmer No. 3757

P. O. Address Marshall, 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40935-
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 792
 (b) Township Arrow Rock Primary Registration District No. 6035 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

David Dennis Durdson
 (a) Residence, No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 2 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec 2, 1939 R. L. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__, to _____, 19__
 I last saw him _____ alive _____, 19__. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____
 (Signed) Robert W. Stauffer, M. D.
 (Address) Marshall

SUPPLEMENTAL

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

