

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

Do not use this space.

16757

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City of *St. Louis Mo* (No. *4915*)

Lotus Ave

File No.

Registered No. **4658**

St.

Ward)

2. FULL NAME *Leslie J. Mullin*

(a) Residence. No. *4915 Lotus Ave* St. *6* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

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 or WIFE of

Ida Mullin

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

Dec 22nd 1878

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

48

4

27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Supt St. Louis Sewer

(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)

Youngstown Ohio

10. NAME OF FATHER

James Mullin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Mary B Bidwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kur R

PARENTS

14.

INFORMANT

(Address)

Ida Mullin 4915 Lotus Ave

15.

FILED

19 *1927*

Mar 6 Starvoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 19 1927

17.

I HEREBY CERTIFY That I attended deceased from

Oct. 19

1922

to

May 19

1927

(that I last saw him alive on *May 14*, 19 *27*, and that death occurred, on the date stated above, at *5:00 A.M.*)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mucous Colitis

9257 120 B

90 W

(duration) *5* yrs. mos. da.

CONTRIBUTORY

Aortic Insufficiency

(SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 Did AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

S. A. VanSoest

M. D

5/19 1927 (Address)

8313 Halls Ferry Rd

*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

DATE OF BURIAL

Valhalla Crem

May 21 1927

20. UNDERTAKER

ADDRESS

Hy Lechner and Co

N. market

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.

www.ancestry.com THIS IS A PERMANENT RECORD

10-12