

13-40
7-39
X25

791
JAN 15 1941

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**

(c) Name of hospital or institution: **St. John's Hospital**

(d) Length of stay: In hospital or institution _____

In this community _____

3. (a) PRINT FULL NAME **Emily Mullen**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Frank W. Mullen**

6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **January 31 1889**

8. AGE:

Years	Months	Days	If less than one day
60	10	8	hr. _____ min. _____

9. Birthplace **Michigan**

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **William Newman**

13. Birthplace **Canada**

14. Maiden name **Caroline Rodgers**

15. Birthplace **Canada**

16. (a) Informant **Frank W. Mullen**

(b) Address **3503a Park Ave.**

17. (a) **Burial** (b) Date thereof **12/12/40**

(c) Place: burial or cremation **St. Peter's Park Cem.**

18. (a) Signature of funeral director **E. J. Schmur**

(b) Address **3125 Lafayette Ave.**

19. (a) **DEC 10 1940** (b) **J. H. Bredlek**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**

(d) Street No. **3503a Park Ave.**

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **8**

year **1940** hour **6:00** minute **P** M.

21. I hereby certify that I attended the deceased from **12/6/40**, 19____, to **12/8/40**, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial degeneration**

Due to **art. coelomus**

Other conditions **asthma**

Major findings: **Cerebral thrombus**

Of operations _____

Of autopsy _____

Duration **1 yr**

PHYSICIAN **[Signature]**

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? _____

(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 **[Signature]**

23. Signature **[Signature]** (M. D. or other) **[Signature]**

Address **[Signature]** Date signed **12/8/40**

AUG 12 1969

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.....

Jose B. Dollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.