S. No. 2
—11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11, 1941

Registration District No. 821

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4553

State File No. 39643

Registrar's No.

1. PLACE OF DEATH:
(a) County: SCOTT
(b) City or town: SIKESTON - LAINI
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: SIKESTON GENERAL HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 (Specify whether
In this community: 4 HR 20 MIN years, months or days)

2. USUAL RESIDENCE OF DEASCED:
(a) State: MISSOURI (b) County: SCOTT
(c) City or town: SIKESTON - HOSPITAL
(If outside city or town limits write "RURAL")
(d) Street No.: 101 West GLADYS
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ 0 years.

3. (a) PRINT FULL NAME: BABY MULLIN
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: INFANT
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: NOVEMBER (Month) 28 (Day), 1941 (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	4 hr. 20 min.

9. Birthplace: SIKESTON (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: INFANT
11. Industry or business: ✓
FATHER
12. Name: SAMUEL EDWARD MULLIN
13. Birthplace: AVALON, (City, town, or county) MO (State or foreign country)
MOTHER
14. Maiden name: LARIA JUSTINE CARROLL
15. Birthplace: FARRENBURG (City, town, or county) MISSOURI (State or foreign country)
16. (a) Informant: MR. S. E. MULLEN
(b) Address: HOLCOMB, MISSOURI
17. (a) Burial + Removal (Burial, cremation, or removal) (b) Date thereof: 11-29-41 (Month) (Day) (Year)
(c) Place: burial or cremation: FARRENBURG, MO Cemetery
18. (a) Signature of funeral director: John F. Nunnelee
(b) Address: Charleston, Mo
19. (a) 12-3-41 (Date received local registrar) (b) T. B. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 28TH year 1941 hour 10 minute 45 P.M.
21. I hereby certify that I attended the deceased from 11-28, 1941, to 11-28, 1941, that I last saw alive on 11-28, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity — Duration: 3 mo
Due to: Placenta Previa of mother
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 59
Of autopsy: no

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): no
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: M. D. Anderson (M. D. or other)
Address: Sikeston Mo Date signed 12-1-41

10 37 (Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.