

Registration District No. 312

Primary Registration District No. 3060607

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 yrs. 9 mos. 27
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson 94
(c) City or town Unknown
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
das.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CARRIE McMULLIN (McMULLEN)

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased About 1872
(Month) (Day) (Year)

8. AGE: Years About 72 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 5-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Mo.

19. (a) 5-24-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st
year 1944 hour 5A minute 45A M.

21. I hereby certify that I attended the deceased from 3-21-
1944 to 5-21, 1944;

that I last saw her alive on May 20, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cardiac Failure

Due to Chronic Myocardial Degeneration

Due to _____

Other conditions Manic Depression
(Include pregnancy within 3 months of death) 55 yrs

Psychosis

Major findings _____
Of operations _____

Of autopsy No autopsy.

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 Daniel Baseman (M. D. _____)

Address State Hosp #4 Date signed 5-21-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100

RECEIVED

District Health Officer No. 4
File Number 644-397
6-17-45

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..... *Maczema*.....

Licensed Embalmer No. 04084

P. O. Address *Farrington*.....

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, fact should be so stated above.