

S. No. 2
M-5-43
I 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29655**
Registrar's No. **8265**

FILED OCT 6 1944 3 18

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**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 Days.**
(Specify whether years, months or days) **0.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Marion**
(c) City or town **Centralia Township, "Rural"**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) **NR.**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: **Stuart Lee Mullen.**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**
4. Sex **male** 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 **10-24-38**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **Tues. 26th**
year **1944** hour **12:30** minute **30** P.M.
21. I hereby certify that I attended the deceased from **9-16-44**
_____ 19____, to **9-26-44.** 19____;
that I last saw him alive on **9-26-44** 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
5 **11** **2** hr. min.

Immediate cause of death
Chronic Glomerulonephritis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
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9. Birthplace **Alton Illinois**
(City, town, or county) (State or foreign country)
10. Usual occupation **None**
11. Industry or business **None**
12. Name **Sholan L. Mullen**
13. Birthplace **Marion County, Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Hilda Smith**
15. Birthplace **Jersey County Illinois**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy **typical kidneys of chro glomerulonephritis**

16. (a) Informant: **St. Mullen**
(b) Address **Walnut Hill, Illinois**
17. (a) Burial (b) Date thereof **Sept. 29, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Alton, Illinois**
18. (a) Signature of funeral director: **Robert H. Streaper**
(b) Address **2521 Edwards St. Alton, Ill.**
19. (a) SEP 28 1944 **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

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: **Gilbert B. Forker** (M. D. or other)
Address **500 So. Kings Highway** Date signed **9/26**

(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.

Signed _____

Licensed Embalmer No. 2474

P.O. Address: Alton, Ill.

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.