

FILED DEC 13 1944

Registration District No. 341

Primary Registration District No. 3025

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Dexter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 7 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay 999
(c) City or town Moark 3
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Albert Mulhollen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Glenna Mulhollen 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased March 12 1910
(Month) (Day) (Year)

8. AGE: Years 34 Months 8 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation School Teacher

11. Industry or business _____

12. Name Lucien Mulhollen

13. Birthplace Texas
(State or foreign country)

14. Maiden name Maith Ann Dall

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

16. (a) Informant Glenna Mulhollen

(b) Address Moark, Ark.

17. (a) Burial (b) Date thereof 11-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation William Cem.

18. (a) Signature of funeral director W. H. Irby

(b) Address Corning, Ark.

19. (a) 12-1-44 (b) Nora Smith
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17
year 1944 hour 3 minute 45 p.a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary occlusion

Due to _____

Due to _____

Other conditions 942
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of 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 3

23. Signature W. H. Irby, M.D. (M.D. or other)

Address Dexter, Mo. Date signed 11/17/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

03331

1934

RECEIVED

District Health Office No. 2,

District File Number 1244-1562

Date Filed 12-7-44

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.....

P. O. Address.....

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.