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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 11593

Registrar's No. 3484

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pronounced dead City Hospt
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 123

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1520 Papin St
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOHN (JACK) MULLANE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White 0

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 April 12 1879
(Month) (Day) (Year)

8. AGE: Years ~~65~~ 66 Months 0 Days 5 If less than one day hr. min.

9. Birthplace IRELAND 11
(City, town, or county) (State or foreign country)

10. Usual occupation Plumbers Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Spranke
(b) Address 2920 A Texas Ave

17. (a) BURIAL (b) Date thereof 4/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NEW S.S.PETER & PAUL

18. (a) Signature of funeral director Thos Kutis & Son
(b) Address 2906 Gravois Ave

19. (a) APR 19 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1945 hour 9 minute 37 P M.

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

Immediate cause of death Cerebral Apoplexy

Due to 83

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)

(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 3

23. Signature Alfred G Perry (M. D. or other)
Address Liberty Corona Date signed 4/19/45

(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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 2906 Harrison

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.