. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19054

FILED JUL 14 1945

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 5734

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: DEACONESS HOSP.
(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 28

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

(d) Street No. 0 NR.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME LAWRENCE B. MULLEN

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 SINGLE

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased APRIL (Month) 23 (Day) 1892 (Year)

8. AGE: Years 53 Months 2 Days 7 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business FARMING

FATHER
12. Name LAWRENCE MULLEN
13. Birthplace GALLAWAY (City, town, or county) IRELAND (State or foreign country)

MOTHER
14. Maiden name LUCINDA RAY
15. Birthplace PULASKI Co (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant LAWRENCE O'FALLON

(b) Address 7005 SUTHERLAND AV.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 7-1-1945 (Month) (Day) (Year)

(c) Place: burial or cremation CUBA MO.

18. (a) Signature of funeral director SMITH + HOLLOW FUNERAL

(b) Address HOME CUBA MO

19. (a) JUL 2 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6-30 day 45
year hour 924 minute A M.

21. I hereby certify that I attended the deceased from 12-26-44, 19, to 6-30-45, 19; that I last saw her alive on 6-30-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Lung

Due to Carcinoma left foot - Primary site in foot

Due to

Other conditions Carcinoma left inguinal region
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma
55
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

23. Signature P B Cappel MD (M. D. or other) SOD

Address 3284 Lobeline ave Date signed 7-1-45

(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 John Ketter

Licensed Embalmer No. 3880

P. O. Address St Louis Mo.

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.