

FILED REG 8 1946

Registration District No. Primary Registration District No. 3006

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
University Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 740 W. Reed St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Sarah E. Mullen

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

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 June 20th 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 7 3 hr. min.

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

10. Usual occupation At home

11. Industry or business.....

12. Name Dominick Mullen

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

14. Maiden name Mary Mullanny

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

16. (a) Informant Joe Mullen

(b) Address Moberly, Mo

17. (a) Burial (b) Date thereof Jan 25th 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly

18. (a) Signature of funeral director Mahon and Son

(b) Address Moberly, Mo

19. (a) 1-25-46 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23rd
year 1946 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from Jan 9, 1946
..... 19..... to Jan 23, 1946 19.....
that I last saw her alive on Jan 23, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Stroke, primary
arteriosclerosis
Due to fracture, neck
of right femur

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions.....
(Include pregnancy within 3 months of death)
Major findings:
Of operations fracture, right femur
Of autopsy none

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? home Moberly Randolph, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

(Specify type of place)
While at work? (e) Means of injury.....

23. Signature Samuel J. Jones (M. D. or other) M.D.
Address Columbia, Mo Date signed Jan 23, 46

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

APR 12 1949

SEP 9 1948

NOV 7 1947

MAR 22 1948

MAY 21 1947

MAY 4 1947

FEB 24 1950

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 2-7-46

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 Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
University Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 da (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Sarah E. Mullen

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 20 1962
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) Mrs R. E. Palmer (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1942 Hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to fracture right femur ← by fall

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident ←
(b) Date of occurrence 12-26-42 ←
(c) Where did injury occur? Moberly, Randolph, Mo ←
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home ←
While at work? _____ (Specify type of place)
(e) Means of injury fall ←

23. Signature M. M. Sims (M. D. or other) MD
Address University Hospital, Columbia Date signed 1-23-46

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

068

SUPPLEMENTARY

2058

MAR 22 1948

MAY 21 1948