

FILED FEB 20 1947

Registration District No. 33

Primary Registration District No. 3011

Registrar's No. 42161

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Stator's Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0  
(Specify whether In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

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

(d) Street No. \_\_\_\_\_  
(If rural, give location) 1/5

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME RHEA Kay Mullnix

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1947 hour 3 minute 25 P.M.

21. I hereby certify that I attended the deceased from Jan 21 1947 to Jan 27 1947  
that I last saw her alive on Jan 27 and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Sept 3 1946  
(Month) (Day) (Year)

Immediate cause of death: Open foramen ovale Duration life

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
0 4 24 hr. min.

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name James D. Mullnix

13. Birthplace Carroll Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Eula Lee Yorkum

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

16. (a) Informant James D. Mullnix

(b) Address Carrollton, Mo.

17. (a) Burial (b) Date thereof 1-28-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem

18. (a) Signature of funeral director Stanley Gibson

(b) Address Carrollton Mo.

19. (a) 1/28/47 (b) Am Herbert Calcutt  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

23. Signature Hamilton Siben (Specify type of place) \_\_\_\_\_  
While at \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

Address Carrollton, Mo. Date signed Jan 29 1947

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-17-47

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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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton 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.**