

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
60 Years (Specify whether years, months or days)

In this community 60 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William C. Mullins

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Josephine Mullins

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

7. Birth date of deceased 9 8 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>9</u>	<u>22</u>hr.min.

9. Birthplace Washington D.C.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Paving Contractor

MOTHER FATHER

12. Name No Record

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Record Office General Hospital

(b) Address Kansas City, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Missouri

19. (a) 7-2-47 (Date received local registrar) (b) Aldredine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1433 Prospect
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 30 year 1947 hour 9 minute 50A. M.

21. I hereby certify that I attended the deceased from June 25, 1947, to June 30, 1947; that I last saw him alive on June 30, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to _____

Due to _____

Other conditions 108
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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 _____

23. Signature W. W. Hart (M. D. or other) JMD
Address Med. Dir. Gen'l Hosp Date signed 7-1-47

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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address 918 Brooklyn
K.C., 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.