

S. No. 2
-12-45
5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23437**
Registrar's No. **849**

Registration District No. **42** Primary Registration District No. **1000**

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

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St Joseph**
(c) Name of hospital or institution: **State Hospital # 2**
(d) Length of stay: In hospital or institution **2 months**
In this community **2 days - 2 mos - 2 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Clinton**
(c) City or town **Platteburg Rural**
(d) Street No. _____
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **John Mullen**
3. (b) If veteran, name war **not given**
3. (c) Social Security No. **not given**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **not given**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 1860**

8. AGE: Years **87** Months **3** Days **?**
If less than one day _____ hr. _____ min.

9. Birthplace **Ireland**

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **John Mullen**
13. Birthplace **Ireland**
14. Maiden name **Unknown**
15. Birthplace **Ireland**

16. (a) Informant **Records State Hospital # 2**
(b) Address **St Joseph, Mo.**

17. (a) **Buried** (b) Date thereof **7 14 47**
(c) Place: burial or cremation **Platteburg Mo**

18. (a) Signature of funeral director **D. W. Heor**
(b) Address **Platteburg Mo**
19. (a) **7-14-47** (b) **G. B. Jenkins**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **12**
year **1947** hour **6:30** minute _____ P. M.
21. I hereby certify that I attended the deceased from **May 10**
1947 to **July 12 1947**
that I last saw h. **in** alive on **July 12 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardiovascular Disease**
Duration **unknown**

Due to _____
Due to _____

Other conditions **Senile Psychosis** **3 years**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (c) Means of injury _____

23. Signature **Delbert P Johnson** (M. D. or other) **M.D.**
Address **State Hospital # 2** Date signed **7/12/47**

6-7-53 1910

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 Donell R. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, N.Y.

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.