

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24457

State File No.

FILED AUG 7 - 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 714

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cabool</u>	
c. LENGTH OF STAY (in this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>no street address</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>SALIE</u>	b. (Middle) <u>MORTON</u>	c. (Last) <u>MULLINS</u>	<u>August 1 1953</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 20, 1885</u>	9. AGE (In years last birthday) <u>67</u>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Montgomery Co. Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>L. C. Morton</u>	13b. MOTHER'S MAIDEN NAME <u>Sara Clark</u>	14. NAME OF HUSBAND OR WIFE <u>William J. Mullins Sr.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>William J. Mullins, Cabool, Mo.</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage with s. Hemiplegia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>33 PX</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/29, 1953, to 8/1, 1953, that I last saw the deceased alive on 8/1, 1953, and that death occurred at 6:55 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ray D. Callaway MD</u>	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>8/3/53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>August 2, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>
	24d. LOCATION (City, town, or county) <u>Cabool, Missouri</u>	(State) _____

DATE REC'D BY LOCAL REG. <u>8-3-53</u>	REGISTRAR'S SIGNATURE <u>Earl Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeier</u>	ADDRESS <u>Springfield Mo</u>
---	---	--	--------------------------------------

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

100-60-1000

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gene B. Hunter

Licensed Embalmer No. 4739

P. O. Address Springfield,

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.