

FILED JUN 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **18364**BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016** Registrar's No. **166**1. PLACE OF DEATH
a. COUNTY **COLE**2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri** b. COUNTY **Cole**b. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN **JEFFERSON CITY** **SWENSIS**c. CITY OR TOWN **JEFFERSON CITY** d. Is Residence within limits of a city or incorporated town? Yes No d. FULL NAME OF HOSPITAL OR INSTITUTION **ST MARKS HOSPITAL**STREET ADDRESS (If rural, give location) **550 LAFAYETTE**3. NAME OF DECEASED
a. (First) **JULIUS** b. (Middle) **LADDIE** c. (Last) **MULKEY**4. DATE OF DEATH (Month) (Day) (Year)
June 9 545. SEX **MALE**6. COLOR OR RACE **NEGRO**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWER**8. DATE OF BIRTH **SEPT 8 - 1906**9. AGE (Years) (Months) (Days) (Hours) (Min.)
4710a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TAXIDRIVER10b. KIND OF BUSINESS OR INDUSTRY
CAPITAL11. BIRTHPLACE (City and State or Foreign Country)
OLEAN MO.12. CITIZEN OF WHAT COUNTRY?
USA13a. FATHER'S NAME
JOHN MULKEY13b. MOTHER'S MAIDEN NAME
HESTER HICKMAN14. NAME OF HUSBAND OR WIFE
John Mulkey Olean Mo15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
L16. SOCIAL SECURITY NO.
L17. INFORMANT'S SIGNATURE OR NAME ADDRESS
John Mulkey Olean Mo18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

also Cause of Kidney

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.**Hypertensive Pneumonia
Femoral**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

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)
024XH

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-10, 1954** to **6-9, 1954** that I last saw the deceased alive on **June 9, 1954**, and that death occurred at **2:50 P.M.**, from the causes and on the date stated above.23a. SIGNATURE (Degree or title)
J. B. Bruce M.D.23b. ADDRESS
334 Madison Jefferson City Mo.23c. DATE SIGNED
6-16-54

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE
Burial 6-11-5424c. NAME OF CEMETERY OR CREMATORY
GREENRIDGE24d. LOCATION (City, town, or county) (State)
MILLER Co Mo.DATE REC'D BY LOCAL OFFICE
June 16-54REGISTRAR'S SIGNATURE
R.P. Bruce M.D.25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Robinson Sewize & Co Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Sylvester Dull*.....
Licensed Embalmer No. 432

P. O. Address *Jefferson*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.