

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27508**  
**3991**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>KANSAS CITY</b> | c. LENGTH OF STAY (In this place)<br><b>30 DAYS</b> | c. CITY OR TOWN<br><b>KANSAS CITY</b>  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>R.C. GENERAL HOSPITAL</b>                    |   | STREET ADDRESS (If rural, give location)<br><b>802. TRACEY 3155</b>  |  |

|  |                                  |   |  |  |  |  |  |
|--|----------------------------------|---|--|--|--|--|--|
| 3. NAME OF DECEASED (First)<br><b>RICHARD</b>  |                                  | 5. (Middle)<br><b>DEAN M. MULLEN</b>                                    |  | c. (Last)  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Aug 16 - 54</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b> |  | 8. DATE OF BIRTH<br><b>MAY 10 - 52</b>                                     |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 1 HRS.<br><b>2</b> Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                        |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>COLUMBUS OHIO</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |

|   |  |   |  |                             |  |
|---|--|---|--|-----------------------------|--|
| 13a. FATHER'S NAME<br><b>JOHN M. MULLEN</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>JERONITA WERNES</b> |  | 14. NAME OF HUSBAND OR WIFE |  |
|---|--|---|--|-----------------------------|--|

|   |  |  |  |  |  |                              |  |
|---|--|--|--|--|--|------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |  | 16. SOCIAL SECURITY NO.<br><b>none</b> |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>ms. John m. mulden</b> |  | ADDRESS<br><b>802 Tracey</b> |  |
|---|--|--|--|--|--|------------------------------|--|

|   |  |  |  |                       |  |                                  |  |
|---|--|--|--|-----------------------|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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)<br><b>Crushing injury of head</b> |  | MEDICAL CERTIFICATION |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES   |  | DUE TO (b)<br><b>&amp; chest</b>   |  | DUE TO (c)            |  | E 9020<br>21                     |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |                       |  |                                  |  |

|                        |  |                                  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|

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|--|--|---|--|--|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><b>Accident</b>            |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>           |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><b>Kansas City Jackson Mo</b> |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>8-15-54 3:30</b> |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?<br><b>Fell from window</b>                            |  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|   |  |  |  |                                    |  |
|---|--|--|--|------------------------------------|--|
| 22a. SIGNATURE Geo. C. Kealhofer (Degree or title)<br><b>Geo. C. Kealhofer, M.D., M.P.H., Col. USAF</b> |  | 23b. ADDRESS<br><b>4050 Broadway, Overland Park, Mo.</b> |  | 23c. DATE SIGNED<br><b>8-16-54</b> |  |
|---|--|--|--|------------------------------------|--|

|  |  |                                 |  |   |  |  |  |
|--|--|---------------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>Aug 18 - 54</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's R.C. M.S.</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>K.C. Mo.</b> |  |
|--|--|---------------------------------|--|---|--|--|--|

|  |  |  |  |   |  |                            |  |
|--|--|--|--|---|--|----------------------------|--|
| DATE REC'D BY LOCAL REG.<br><b>8-17-54</b> |  | REGISTRAR'S SIGNATURE<br><b>Bessie Smith</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Smith</b> |  | ADDRESS<br><b>K.C. Mo.</b> |  |
|--|--|--|--|---|--|----------------------------|--|

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

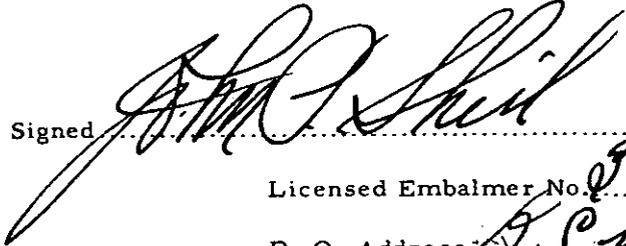
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 36.....

P. O. Address: A. C. M.....

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.