

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42654**  
Registrar's No. **10796**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS Mo</b> )		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>3005 - SHENANDOAH</b>		e. STREET ADDRESS (If rural, give location) <b>3005 - SHENANDOAH 2179</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>JAMES</b> b. (Middle) <b>P.</b> c. (Last) <b>MULLIGAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 24 1954</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>APRIL 10 1900 54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESS MAN (RETIRED)</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri 0</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>STAR TIMES</b>		12. CITIZEN OF WHAT COUNTRY? <b>U - S - A</b>	
13a. FATHER'S NAME <b>JAMES MULLIGAN</b>		13b. MOTHER'S MAIDEN NAME <b>MARY GRAY</b>	
14. NAME OF HUSBAND OR WIFE <b>ROSEMARY MULLIGAN (DECD)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JAMES H. MULLIGAN 3005 - SHENANDOAH</b>	

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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		ANTECEDENT CAUSES			
DUE TO (b) <b>Adenocarcinoma of colon with metastasis;</b>		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic Heart Disease</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? <b>153x</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 **500 P.** m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <b>James M. Kelly Deputy Coroner</b>		23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>11. 27. 54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>Nov. 27 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEM.</b>	
24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, Mo</b>					

DATE REC'D BY LOCAL REG. <b>NOV 27 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thomas Kulis 2906 Harris</b>	
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(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 \_\_\_\_\_

Licensed Embalmer No. <sup>434</sup> \_\_\_\_\_

P. O. Address <sup>2906</sup> \_\_\_\_\_

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.