

FILED APR 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11193**
Registrar's No. **3196**

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 Illinois b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Kinmundy	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 Jewish Hospital		e. STREET ADDRESS (If rural, give location) 812⁰g	

3. NAME OF DECEASED (Type or Print) a. (First) Lulu b. (Middle) _____ c. (Last) Mulvaney			4. DATE OF DEATH (Month) (Day) (Year) March 27, 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 27, 1886	9. AGE (In years last birthday) 70	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Marion Co., Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Stephen Wagner	13b. MOTHER'S MAIDEN NAME Sarah Roberts	14. NAME OF HUSBAND OR WIFE Robert E. Mulvaney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Fern Baker, 2836a Accomac St.

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, ashenia, 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* Acute myocardial infarction		1 da.
	II. OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis		15 yrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Generalized arteriosclerosis	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) 4200
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 3-27-56	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from **March 27, 1956**, to **March 27, 1956**, that I last saw the deceased alive on **March 27, 1956**, and that death occurred at **10:55 a.m.**, from the causes and on the date stated above **3-28-56**

23a. SIGNATURE A. E. Braverman (Degree or title) M.D.	23b. ADDRESS Jewish Hosp. Kinmundy, Ill.	23c. DATE SIGNED 3/28/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-28-56	24c. NAME OF CEMETERY OR CREMATORY Parker Cemetery
24d. LOCATION (City, town, or county) (State) Kinmundy, Ill.		

DATE REC'D BY LOCAL REG. MAR 29 1956	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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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 *G. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *11 Lou*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.