

pt. Health,  
c., & Welfare  
S. Public  
alth Service

V. S. 300  
Rev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39010  
STATE FILE NUMBER

FILED NOV 6 1957

6284

Registration District No. 375 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Wright</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Montgomery Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Lynchburg-Montgomery Twp.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Highway A</b>		Length of stay in lb <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>Highway A</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Robert</b> Last <b>Mullens</b>			4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1889</b>
9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Wabeleau, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Anthony Mullens</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>
14. NAME OF HUSBAND OR WIFE <b>Mrs Ora Ellen Mullens</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>524-14-7665A</b>
17. INFORMANT <b>Mrs Ora Mullens, Lynchburg, Missouri</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self-Inflicted Gunshot Wound Thru Frontal Lobe of Brain, Exiting thru the Parasagittal - Immediate</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>976X</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <b>2:00</b> a.m. <b>10/15/1957</b> p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>His farm home</b>	
20f. CITY, TOWN, OR LOCATION <b>Lynchburg</b>		COUNTY <b>Wright</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>at Death on 10/15/57</b> and last saw her alive on _____ Death occurred at <b>2:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Richard B. Mitchell D.O.</b>		22b. ADDRESS <b>Mtn. Grove, Missouri</b>	
22c. DATE SIGNED <b>10-21-57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>10/17/1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mountain Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Wright County, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Barber Funeral Home Mtn. Grove, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-6-57</b>	
26. REGISTRAR'S SIGNATURE <b>Thomas C Dunder</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

WRIGHT CO. HEALTH DEPT.  
County File Number 1157-131  
Date Filed 11-4-57

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 *George Stapp* .....  
Licensed Embalmer No. 3161  
P. O. Address *Wm. Stapp*

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.