

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024397
STATE FILE NUMBER

360
FILED JUN 17 1958 Registration District No. _____ Primary Registration District No. 6215 Registrar's No. 106

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clear Creek Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>El Dorado Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt. #1</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Rt. #1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Mullins</u> Last <u>Mullins</u>			4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1902</u>		9. AGE (In years last birthday) <u>56</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm Cedar Co., Mo.</u>		11. BIRTHPLACE (City and state/country) <u>U.S.B.</u>		
13a. FATHER'S NAME <u>Robert Mullins</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Dale</u>		14. NAME OF HUSBAND OR WIFE <u>Thelma Mullins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if so, unknown) (If yes, give year or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thelma Mullins Rt. #1 - El Dorado Springs</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary occlusion</u>		
	DUE TO (c) <u>Coronary arteriosclerosis 4201</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>6-4-58</u> to <u>6-4-58</u> and last saw him alive on <u>6-4-58</u> Death occurred at <u>6:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>Robert L. Mager M.D.</u>		22b. ADDRESS <u>El Dorado Springs, Mo.</u>		22c. DATE SIGNED <u>6-6-58</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-8-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery Vernon Co., Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Vernon Co., Mo.</u>	
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24. FUNERAL DIRECTOR <u>Shirley Carothers El Dorado Springs</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>6-9-1958</u>		26. REGISTRAR'S SIGNATURE <u>Arnold E. Perry</u>	
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(License Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed.

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 *W. E. Carsthus*

Licensed Embalmer No. *4419*
P. O. Address *La Grange, Ill.*

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.