

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026500
STATE FILE NUMBER

FILED AUG 7 1958 Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 140

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY <u>Phelps</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps Co. Mem. Hosp</u>		Length of stay in 1b <u>1 WEEK</u>	d. STREET ADDRESS <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Joseph</u> Last <u>Mullen</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1887</u>	9. AGE (In years last birthday) <u>71</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>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Leasburg Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Lawrence Mullen</u>		13b. MOTHER'S MAIDEN NAME <u>Luinda Roy</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. <u>NOT available</u>	17. INFORMANT Name <u>Paul Mullen</u> Address <u>Cuba Mo.</u>		
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>Cerebral thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis and</u>					<u>years</u>
DUE TO (c) <u>auricular fibrillation</u>					<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4331</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 <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>5 June 58</u> to <u>28 July 58</u> and last saw ^{her} _{him} alive on <u>28 July 58</u> Death occurred at <u>6:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ronald Van Arsdell, M.D.</u>			22b. ADDRESS <u>Bourbon, Mo.</u>		22c. DATE SIGNED <u>29 July 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-31-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mullen</u>		23d. LOCATION (City, town, or county) (State) <u>Cuba Mo</u>
24. FUNERAL DIRECTOR <u>Herman Thayer</u>		ADDRESS <u>Cuba Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 30, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>

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. All diseases in Part I must be causally related.

RECEIVED

Phelps County Health Officer,

County File Number 107

Date Filed AUG 6 1958

YS AUG 7 1959

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 Norman E. Hoener

Licensed Embalmer No. 4673

P. O. Address Chico, Mo.

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.