

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007481

STATE FILE NUMBER
2 2178

FILED MAR 10 1959

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

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hosp.</u>		Length of stay in 1b <u>65 years</u>	
d. STREET ADDRESS <u>5864 Cates Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>BEACH</u> Last <u>MULLEN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1866</u>
9. AGE (In years) <u>92</u> (at birthday)		FUNDER 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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Newark, New Jersey / USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Henry O. Beach</u>	
13b. MOTHER'S MAIDEN NAME <u>Emily Carpenter Ford</u>		14. NAME OF HUSBAND OR WIFE <u>William L. Mullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Alice Marie Mullen</u>		Address <u>5864 Cates Ave.</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>Intestinal Obstruction Probably mesenteric thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4d+</u>
DUE TO (b) <u>Arteriosclerotic heart disease - Failure 2 hrs</u>			<u>20 yrs +</u>
DUE TO (c) <u>General Arteriosclerosis</u>			<u>20 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Staphylococcal toxic shock. 30 days + severe 20 yrs + 1st Glaucoma. Evident 20 yrs + 1 Hip fracture 5 yrs</u>			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.) <u>4:200</u>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
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>9-18-44</u> , to <u>3-1-59</u> and last saw her alive on <u>2-28-59</u> Death occurred at <u>3:55 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. Fred W. Clark</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>864 Hamilton Blvd St. Louis 12 Mo</u>	
22c. DATE SIGNED <u>3-2-59</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<u>Burial</u>		<u>March 3, 1959</u>	<u>Bellefontaine Cem.</u>
23d. LOCATION (City, town, or county)		(State)	
<u>St. Louis, Mo.</u>			
24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 2 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

m & B

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 *Joseph E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6125 Delm*

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.