

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1959

59-026995

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6701** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in 1b 3 Wks		c. CITY OR TOWN Affton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St Anthony's Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6602 Bonnie Court		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARY Middle C Last MULLEN				4. DATE OF DEATH Month July Day 16 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-2-1876	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME Santo Maglio			13b. MOTHER'S MAIDEN NAME Catherine Capelli			14. NAME OF HUSBAND OR WIFE James J Mullen (dec'd)			
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 James J Mullen 1921 Ann				Address	
18. CAUSE OF DEATH (Enter only cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIC COMA							INTERVAL BETWEEN ONSET AND DEATH 2 wks		
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 Generalized Arteriosclerosis						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 7/9/59 to 7/16/59 and last saw ^{her} _{him} alive on 7/15/59 Death occurred at 12:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Charles [Signature] (Occ, free or title)				22b. ADDRESS 7430 VIRGINIA			22c. DATE SIGNED 7/17/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 18 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St Louis		STATE Mo		
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois			ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 17 '59		26. REGISTRAR'S SIGNATURE Loan Smith, M.D. SIP		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1:20:41
Phila
D. 1906

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Dava

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