

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 25 1960

60-000837

STATE FILE NUMBER

Registration District No. 06 Primary Registration District No. 5327 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Crawford</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) OR TOWN <u>Benton Twp.</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Leasburg</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lick Creek Community</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>(Nmi)</u> Last <u>Mullen</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Female</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>Nov. 12 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>
				IF UNDER 24 HR Hours <u></u> Min. <u></u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</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>Dennis Mullen</u>		13b. MOTHER'S MAIDEN NAME <u>Bridgett Radigan</u>		14. NAME OF HUSBAND OR WIFE <u>Never married</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dennis Mullen Leasburg, 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>Chronic Endocarditis</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>/</u> DUE TO (c) <u>/</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			

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		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 Jan 10 to Jan 19 1960 and last saw her/him alive on Jan 12 1960
Death occurred at home 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. F. Irwin MD</u> (Degree or title)		22b. ADDRESS <u>Leasburg, Mo</u>		22c. DATE SIGNED <u>Jan 20 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-22-60</u>	23c. NAME OF CEMETERY <u>Sacred Heart</u>	23d. LOCATION (City, town, or county) <u>Leasburg</u> (State) <u>Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Norman C. Hoener Cuba Mo</u>		25. DATE RECD. BY LOCAL REG. <u>January 27, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Paul C. Hamilton</u>

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 Norman C. Adams

Licensed Embalmer No. 467

P. O. Address Cuba

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.