

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013068
STATE FILE NUMBER

AMENDED

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 48

FILED APR 26 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Clinton</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u> Length of stay in 1b <u>50 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Comm. Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u> c. CITY OR TOWN <u>Cameron</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>321 N.Main.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA ANN MULLIS</u>				4. DATE OF DEATH Month Day Year <u>April 11, 1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</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>10-25-1881</u>		9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Day*		IF UNDER 24 HR 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>Home</u>				11. BIRTHPLACE (City and state or country) <u>Gower, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Geo. Burnett</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Nash</u>				14. NAME OF HUSBAND OR WIFE <u>O.B. Mullis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>						17. INFORMANT Address <u>O.B. Mullis, Cameron, 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>Bronchopneumonia</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>obesity chronic cholelithiasis</u> <u>Parkinsons Disease</u>								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 <u>12-29-50</u> to <u>4-11-61</u> and last saw ^{her} him alive on <u>4-10-61</u> Death occurred at <u>4:50 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>S. J. Wetherston M.D.</u>					22b. ADDRESS <u>Cameron Mo</u>			22c. DATE SIGNED <u>4-13-61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graceland</u>		23d. LOCATION (City, town, or county) (State) <u>Cameron, Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Poland Funeral Home, Cameron, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>4-17-61</u>		26. REGISTRAR'S SIGNATURE <u>Frances Crawford</u>						

ITEM NO. SHOULD READ

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 4435

P. O. Address Cammon, ?

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.