

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-016945**

STATE FILE NUMBER

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 10-1961

**FILED MAY 23 1961**

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>Cuba</u>		Length of stay in 1b <u>44 years</u>	c. CITY OR TOWN <u>Cuba</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>207 N. Davis</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Mullen</u>			4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>male</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>May 4 1880</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier</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>Lucinda Ray</u>		14. NAME OF <del>WIFE</del> WIFE <u>Nora Davis Mullen - Dead.</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>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>William J. Mullen Cuba, Mo.</u>
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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>Carcinoma of Lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>
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 (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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 checked="" 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 1948 to May 1961 and last saw him alive on May 13 1961  
Death occurred at 6:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Frank A. Selders M.D.</u>	22b. ADDRESS <u>Cuba, Mo.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 20 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	23d. LOCATION (City, town, or county) (State) <u>Leasburg MO</u>
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24. FUNERAL DIRECTOR <u>Norman C. Hoener</u>	ADDRESS <u>Cuba, MO</u>	25. DATE RECD. BY LOCAL REG. <u>May 20 1961</u>	26. REGISTRAR'S SIGNATURE <u>Frank A. Selders</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE REVISED

PROPERTY OF

SHOULD READ

FORM NO.

JUL 28 1961

**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 C. Hansen

Licensed Embalmer No. 4673

P. O. Address Cuba, 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.