

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1823-61-027795 FILED JUL 25 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		Length of stay in 1b 5 1/2 Weeks	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Henningers Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2818 Dalton Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROSE Middle WALTHER-MULLINS Last			4. DATE OF DEATH Month June Day 29 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1902	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler-Artcraft Venetian Blind Co.		10b. KIND OF BUSINESS OR INDUSTRY Allentown, Penn.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Kloiber		13b. MOTHER'S MAIDEN NAME Rosa Unknown		14. NAME OF HUSBAND OR WIFE Sid Mullins		

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 Sid Mullins 2818 Dalton Ave.
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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) central thrombosis, extensive		INTERVAL BETWEEN ONSET AND DEATH 3-4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) central arteriosclerosis	
	DUE TO (c) arteriosclerosis	
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

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 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 May 18, 1961 to June 29, 1961 and last saw her June 28, 1961 Death occurred at 7:25 A. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Douglas C. Crowell, M.D.	22b. ADDRESS 9764 Tesson Ferry Rd	22c. DATE SIGNED 6/29/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 1, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
25. DATE RECD. BY LOCAL REG. 6-30-61		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

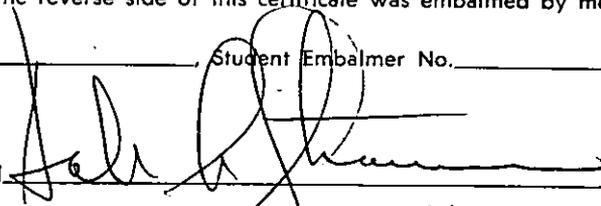
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.