

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006851

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1435 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 15 1963	
1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 1 wk. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Luke's Hospital Inside Limits. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Phelps c. CITY OR TOWN Rolla Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2 Vichy Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE MEADOWS MULLENBURG	
4. DATE OF DEATH Month Day Year 3 3 1963	
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 6-9-90
9. AGE (last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and state or country) Waverly Junction, Iowa	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Meadows	
13b. MOTHER'S MAIDEN NAME Agnes Brown	
14. NAME OF HUSBAND OR WIFE Dr. Garrett A. Mullenburg	
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. [Redacted]	
17. INFORMANT Address Mrs. Dorothy Kasten; 6136 Manning Raytown, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis <i>Estimated - 3 mos.</i> DUE TO (b) Probably metastatic from Rt. Breast. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerotic, hypertensive disease and emphysema	
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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. _____ 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 3/27/63 to 3/3/63 and last saw him alive on 3/3/63 . Death occurred at 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Describe or title) William F. Sanders M.D.	
22b. ADDRESS 411 Nichols Road K.C. Mo	
22c. DATE SIGNED 3/4/63 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-5-63
23c. NAME OF CEMETERY OR CREMATORY Ozark Memorial Gardens	
23d. LOCATION (City, town, or county) Rolla Phelps Co., Missouri	
24. FUNERAL DIRECTOR NULL & SONS FUNERAL HOME, ROLLA, MO.	25. DATE RECD. BY LOCAL REG. 3-4-63
26. REGISTRAR'S SIGNATURE Ruth H Long	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **William F. Sanders** MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

MAY 20 1963

JUL 26 1963

1120

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,

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or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Sidman
Licensed Embalmer No. 4536
P. O. Address Kansas City, 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.