

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013628

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3271**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

281207 I

3

4 0

5 1

6

7 1

8 2

9

10

11

12 68-0

13

68

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |
|--|---|
| <b>FILED MAR 28 1963</b>   |   |
| 1. PLACE OF DEATH  |   |
| a. COUNTY <b>Illinois</b>  |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b  |   |
| c. CITY OR TOWN <b>Edwardsville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| d. STREET ADDRESS (if outside, give location) <b>901 Holyoake</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED First Middle Last  |   |
| <b>Charles John Mulach</b>   |   |
| 4. DATE OF DEATH Month Day Year <b>March 19, 1963</b>  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   |
| 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                                       | 8. DATE OF BIRTH <b>5/25/1902</b>   |
| 9. AGE (last birthday) <b>60</b>   | IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery &amp; Meat Market</b>  |
| 11. BIRTHPLACE (City and state or country) <b>Worden, Ill.</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>  |   |
| 13a. FATHER'S NAME <b>Joseph B. Mulach</b>   |   |
| 13b. MOTHER'S MAIDEN NAME <b>Anna Vogt</b>   |   |
| 14. NAME OF HUSBAND OR WIFE <b>Harriet</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of ) <b>No</b>   |   |
| 16. SOCIAL SECURITY NO. [REDACTED]   |   |
| 17. INFORMANT Address <b>Harriet Mulach, Edwardsville, Ill.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:  |   |
| IMMEDIATE CAUSE (a) <b>Liver failure</b>   |   |
| DUE TO (b) <b>Metastatic Carcinoma</b>   |   |
| DUE TO (c) <b>1561</b>   |   |
| 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                              |   |
| 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 s.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 <b>1-15-63</b> to <b>3-19-63</b> and last saw him alive on <b>3-19-63</b>   |   |
| Death occurred at <b>2:00 pm</b> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |
| 22a. SIGNATURE (Degree or title) <b>W. J. Carter M.D.</b>  | 22b. ADDRESS <b>41 N. Central, St. Louis 5</b>  |
| 22c. DATE SIGNED <b>3-20-63</b> (State)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   | 23b. DATE <b>3-22-63</b>  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Valley View Garden of Memory</b>   |   |
| 23d. LOCATION (City, town, or county) (State) <b>Edwardsville Twp., Ill.</b>   |   |
| 24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>   |   |
| 25. DATE RECD. BY LOCAL REG. <b>MAR 20 1963</b>  |   |
| 26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>  |   |

USE BLACK INK OR TYPEWRITER RIBBON

**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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.