

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049795

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12321

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 20 1963

VS 300  
Rev. 4/59  
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DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
SHOULD READ  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1417 S. 10th</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank J. Mulligan</b>						4. DATE OF DEATH Month Day Year <b>Dec. 11 1963</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12/22/01</b>		9. AGE (last birthday) <b>61</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>Sales Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco Shop</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>Frank Mulligan</b>				13b. MOTHER'S MAIDEN NAME <b>Mary McDonough</b>				14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>Yes WW# 1</b>				16. SOCIAL SECURITY NO. <b>36a</b>		17. INFORMANT Address <b>Mary Schmitt 5005 Alexander</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>										INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis - generalized</b>										<b>5 yrs</b>	
DUE TO (c) <b>331x</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>								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.) <b>None</b>							
20c. TIME OF INJURY Hour a.m. p.m. <b>-</b>		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.) <b>None</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>None</b>									
21. I attended the deceased from <b>5-29-63</b> to <b>12-11-63</b> and last saw him alive on <b>11-7-63</b> Death occurred at <b>950a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>Edward P. Reck MD</b>						22b. ADDRESS <b>4500 Olive St Louis (8) Mo</b>			22c. DATE SIGNED <b>12-12-63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 14, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Galvany Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Thomas Kates 2906 Grassis</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 13 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loant 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

*J. A. Humphrey*

Licensed Embalmer No.

*4772*

P. O. Address

*2906 Graves*

*Mr. Bell  
4500 Olive -  
St. Louis 17  
Then Coroner's office*

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.