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SEP 23 1940
Registration District **447**

Primary Registration District No. **4288**

Registrar's No. **27**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I. PLACE OF DEATH:

(a) County **Lewis**
(b) City or town **Labella**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) **2**
(d) Length of stay: In hospital or institution _____
In this community **53 yrs. 5 mos. 17 days**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lewis**
(c) City or town **Labella**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Leo Harvey Mulina**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **327-05-6959**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **12th** year **1940** hour **8** minute **30** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Florence J. Mulina**
6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **February 25 1887**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 22nd** 1940 to **May 12** 1940
that I last saw him alive on **Aug 12th** 1940 and that death occurred on the date and hour stated above.
Immediate cause of death **Gas poisoning** Duration _____

8. AGE: Years **53** Months **5** Days **17** If less than one day _____ hr. _____ min.

Due to **Gas escaping from**
Fluorid air
Due to _____

9. Birthplace **Labella Missouri**
(City, town, or county) (State or foreign country)

Other conditions **Aschma + Bronchitis**
& Weak heart - Myocarditis
Major findings: _____
Of operations _____
Of autopsy **17 14**

10. Usual occupation **Printer**

11. Industry or business _____
12. Name **Charles W. Mulina**
13. Birthplace **Indian**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Zimmerman**
15. Birthplace **Labella Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Florence Mulina**
(b) Address **Labella Mo**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **Aug 12**
(c) Where did injury occur? **At his home**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At Home
While at work? **No** (Specify type of place) (Means of injury) **Gas**

17. (a) **Burial** (b) Date thereof **Aug 14-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Labella Cemetery**

18. (a) Signature of funeral director **James J. Godertson**
(b) Address **Labella, Mo**

23. Signature **A. J. Sillars** (M. D. or other) _____
Address **Labella Mo** Date signed _____

19. (a) **Aug** (b) _____
(Date received local registrar) (Registrar's signature)

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

Norman D. Goder

Registered Apprentice No. ~~3721~~

working under my personal supervision.

Signed

Norman D. Goder

Licensed Embalmer No. *3721*

P. O. Address

LaBelle, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28958

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 477

Primary Registration District No. 4288

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lewis

(b) City or town La Belle
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Leo Harvey Muliney

3. (b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH: Month Aug day 12
year 1940 hour _____ minute _____ M.

4. Sex m 5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years 33 Months 5 Days 17 If less than one day _____ hr. _____ min.

21. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

Major findings: _____

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Aug. 14, 1940 (b) P. W. Jennings, M.D.
(Date received local registrar) (Registrar's signature)

23. Signature A. H. Leonard (M. D. or other) _____
Address La Belle Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

