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13-40
17-39
X23159

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **1828**

1. PLACE OF DEATH:

(a) County.....

(b) City or town. **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 Days**
(Specify whether)

In this community..... **Life**
years, months or days)

3. (a) PRINT FULL NAME **Margaret Mullen**

3. (b) If veteran, name war..... **Unknown**

3. (c) Social Security No. **Unknown**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Widowed**

6. (b) Name of husband or wife **Unknown**

6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **April 6, 1869**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	9	22	hr. min.

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

10. Usual occupation **Nil.**

11. Industry or business **Nil.**

12. Name **Pat Nugent**

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

14. Maiden name **Mary Finnell**

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

16. (a) Informant **Ann Morrison**
(b) Address **St. Louis City Hospital #1.**

17. (a) **Cremation** (b) Date thereof **2 27 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or crematory **City Crematory**

18. (a) Signature of funeral director **W. J. White**

(b) Address **City Hospital #1**

19. (a) **FEB 23 1941** (b) **J. W. Zedek**
(Date recorded locally) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State **Missouri** (b) County **17**

(c) City or town **St. Louis** **9 11**
(If outside city or town limits, write "RURAL")

(d) Street No. **3640a Easton Avenue**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **0** x **11** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **28**, year **1941** hour **8:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **January 21**, 19**41** to **January 28**, 19**41**; that I last saw her alive on **January 28**, 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Valvular Heart Disease (Aortic + Mitral Stenosis)** Duration **9 5 yrs.**

Due to **Arterio sclerosis**

Due to **Chronic Myocarditis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **As above.**

Of autopsy **As above.**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?.....

While at work?..... (Specify type of place) (Specify means of injury)

23. Signature **Samuel Coates** (a. D. or other) **D**
Address **1515 Lafayette Avenue**, Date signed **2/10/41**

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

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.