

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**4320 Lindell Blvd.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Two Weeks** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4320 Lindell Blvd.**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) **No**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Walter Lee Mullen**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **321-20-6179**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Alice Ione** 6. (c) Age of husband or wife if alive **32** years

7. Birth date of deceased **December 3 1902**  
(Month) (Day) (Year)

8. AGE: Years **40** Months **4** Days **11** If less than one day hr. min.

9. Birthplace **Virginia** **Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Letter Carrier**

11. Industry or business \_\_\_\_\_

12. Name **William Mullen** **Virginia** **Illinois**

13. Birthplace **Margaret Jacobs** (State or foreign country)

14. Maiden name **Virginia** **Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Alice Ione Mullen**

(b) Address **4320 Lindell Blvd.**  
**Removal** (b) Date thereof **4-17-43**

(c) Place: burial or cremation **Virginia, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe Inc.**

(b) Address **4700 Washington Blvd.**  
**APR 15 1943** (Date received local registrar)  
**J. F. Budick** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14** 19**43**  
year **1943** hour **11** minute **30P** M.

21. I hereby certify that I attended the deceased from **April 1** 19**43** to **April 14** 19**43**  
that I last saw him alive on **April 14** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Bowel obstruction** Duration **2 wks**  
**Due to Volvulus Peritonitis**  
**Bilateral Pneumonia**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **122**

Major findings: Of operations \_\_\_\_\_

Of autopsy **Intestinal Obstruction Peritonitis**  
**Bilateral Pneumonia**

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) (f) Means of injury \_\_\_\_\_

23. Signature **John J. Ryan** (M. D. or other) **MD**

Address **2602 N. Grand** Date signed **4-15-43**

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 *Robert E. Hoff*.....

Licensed Embalmer No. *2991*.....

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.**