DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 14 1947

Registration District No. 127

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13226

Primary Registration District No. 3464

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: The Family Home, Willard
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 17 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Willard. 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dueward Joseph Mulanax

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased January (Month) 2, (Day) 1910 (Year)

8. AGE:

Years	Months	Days	If less than one day
37	3	28	hr. min.

9. Birthplace Walnut Grove, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation An invalid for years

11. Industry or business

FATHER
12. Name Joseph G. Mulanax 0
13. Birthplace Pro Tem, Missouri
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Cosha Neff 0
15. Birthplace Morrisville, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Floretta Horn, Sister.
(b) Address Willard, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof May 4 1947 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Walnut Grove, Mo.

18. (a) Signature of funeral director Greenwade Funeral Home
(b) Address Willard, Missouri

19. (a) May 3 1947 (Date received local registrar) (b) Jane Appleby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30th, year 1947 hour 5.00 minute P. M.

21. I hereby certify that I attended the deceased from March 15, 1947, to April 30, 1947; that I last saw him alive on April 30, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fibro-myo-sarcoma	1½ yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place) 0
While at work? (e) Means of injury

23. Signature Kenneth C. Coffee (M. D. or other) M.D.
Address Springfield, Mo. Date signed 5-2-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office,
County File Number 47-5-52
Date Filed 5-13-47

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 Mrs E. W. Greenwade

Licensed Embalmer No. 2095

P. O. Address Willard, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

2B
45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 127 Primary Registration District No. 3464 Registrar's No. 38

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Willard
(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Durward J. Mulanax

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 2 (Month) (Day) (Year)

8. AGE: Years 37 Months 3 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 22 year 1947 hour minute M.

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

Immediate cause of death Generalized Fibro-Myo-Sarcoma secondary to primary site in left lobt.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Kenneth C. Collett (M. D. or other) M.D.
Address Springfield, Mo. Date signed 5-16-47

SUPPLEMENTARY

55E

13226

Kenneth C. Coffee M.D.
Sp. [illegible]