7. S. No. 2
0M—1/47
ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 6 1947

Registration District No. 323

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36765

Primary Registration District No. 4474

Registrar's No. 29

1. PLACE OF DEATH:
(a) County: SALINE
(b) City or town: SWEET SPRINGS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 208 Bridge St
(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: 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: SALINE
(c) City or town: SWEET SPRINGS
(If outside city or town limits, write "RURAL")
(d) Street No.: 208 BRIDGE ST
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: MARTHA EVELINE MULLENAX
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: Joseph Mullenax
6. (c) Age of husband or wife if alive: 75 years
7. Birth date of deceased: MAR (Month) 19 (Day) 1884 (Year)
8. AGE: Years 63 Months 7 Days 8 If less than one day ..... hr. ..... min.
9. Birthplace: SALINE Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business: AT HOME
MOTHER FATHER
12. Name: CHAS. M. BOWLER
13. Birthplace: KY (City, town, or county) (State or foreign country)
14. Maiden name: LIZA ANNA HOLLAWAY
15. Birthplace: VA (City, town, or county) (State or foreign country)
16. (a) Informant: Joseph Mullenax
(b) Address: Sweet Springs, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 10-29-47 (Month) (Day) (Year)
(c) Place: burial or cremation: FAIRVIEW CEMETERY
18. (a) Signature of funeral director: R. C. CARTER
(b) Address: SWEET SPRINGS, MO
19. (a) 10/29/47 (Date received by local registrar) (b) Orley Andrew (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October Day 25
year 1947 hour 9:06 minute P. M.
21. I hereby certify that I attended the deceased from 25 Oct 1947, 19..., to Death, 19...; that I last saw her alive on October 27, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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? Means of injury
23. Signature: Joseph P. Doyle (M. D. or other) M.D.
Address: Sweet Springs Date signed: 10-28-47

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

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-3-47

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 R C Carter

Licensed Embalmer No. 3513

P. O. Address Lamar Springs 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, fact should be so stated above.