

Called MAY 24 1954

STANDARD CERTIFICATE OF DEATH

State File No. 16628

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 148

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2700 Market St.,		d. STREET ADDRESS (If rural, give location) 2700 Market St.,	

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) Thomas William Mullinix			4. DATE OF DEATH (Month) (Day) (Year) 5-11-54		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) About 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Macon Co., Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Noah Mullinix	13b. MOTHER'S MAIDEN NAME Jane Cooley	14. NAME OF HUSBAND OR WIFE Mattie Mullinix
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Gus Lucas, 2700 Market	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION Hannibal, Mo.		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pneumonia</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cerebral Thrombosis</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 491X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) m:	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5/7/54 to 5/11/54, that I last saw the deceased alive on 5/10/54, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS Hannibal Mo	23c. DATE SIGNED 5/18/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/13/54	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.
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DATE REC'D BY LOCAL REG. 5/18/54	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Hannibal Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED MAY 21 1954
MARION CO. HEALTH DEPT.
DATE FILED MAY 21 1954

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed JM O'Donnell

Licensed Embalmer No. 3889

P. O. Address Hannibal 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.