

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30050

No. 300  
10.48

FILED OCT 5 1954

224  
1097- State File No.  
5997  
159 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>59</u>		PRIMARY REG. DIST. NO. <u>5997</u>		Registrar's No. <u>159</u>	
1. PLACE OF DEATH a. COUNTY <u>CASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>BAUENWORTH</u>			
b. CITY, OR VILLAGE OR TOWN <u>REGULAR</u> (RURAL)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>LEAVENWORTH ARMY POST</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Highway #71 Bypass</u>				d. STREET ADDRESS (If rural, give location) <u>208 THIRD U.S. ARMY POST</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GENEVIEVE</u>		b. (Middle) <u>MARIE</u>		c. (Last) <u>MULLENS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 30 1954</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 4 1954</u>		9. AGE, (In years last birthday)	IF UNDER 1 YEAR Months <u>26</u>	IF UNDER 2 HRS. Hours <u>5</u> Mins. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>U.S. ARMY POST LEAVENWORTH KANS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>FRANK O. MULLENS</u>			13b. MOTHER'S MAIDEN NAME <u>JOYCE LYNN</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr Howard Seim Springfield Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Trauma</u>  ANTECEDENT CAUSES DUE TO (b) <u>Skull Fracture</u> DUE TO (c) <u>car accident</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, city block, etc.) <u>Highway 71 &amp; B.</u>		21c. CITY, TOWN OR TOWNSHIP (COUNTY) <u>Leavenworth Cass</u>		(STATE) <u>Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9 30 54 7P</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>car accident</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Edward J. Crow</u>				23b. ADDRESS <u>Pleasant Hill, Mo</u>		23c. DATE SIGNED <u>9/30/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-1-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Leavenworth</u>		24d. LOCATION (City, town, or county) (State) <u>Leavenworth Kas</u>		
DATE REC'D BY LOCAL REG. <u>Oct 1, 1954</u>		REGISTRAR'S SIGNATURE <u>Dora Barrard</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Watkins Bros. Harrisonville, Mo</u>			

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

0190

RECEIVED  
OCT 4 1954  
CLATSOP COUNTY  
HEALTH DEPARTMENT

OCT 27 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 Robert W. Atkinson

Licensed Embalmer No. 4902

P. O. Address Harrisonville, 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.