

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35971**
9605

FILED NOV 16 1956
BIRTH NO. **82057-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			• STREET ADDRESS (If rural, give location) 1710 1817a Michigan Ave.					
3. NAME OF DECEASED (Type or Print) Twingirl #2		a. (First) Twingirl	b. (Middle) #2	c. (Last) Mulitsch	4. DATE OF DEATH (Month) (Day) (Year) Oct. 20 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH October 20 1956	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.				
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Robert J. Mulitsch		13b. MOTHER'S MAIDEN NAME Joan Teppmeyer				
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.				
17. INFORMANT'S SIGNATURE OR NAME Robert J. Mulitsch		17. ADDRESS 1817a Michigan Ave.						
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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Birth Premature birth 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.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 776 x			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 10-20-56 , to 10-20 , 19 56 , that I last saw the deceased alive on 10-20 , 19 56 and that death occurred at 10:15 P.m. , from the causes and on the date stated above.								
23a. SIGNATURE E. H. Bowdern M.D.			23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 10-22-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/22/56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's						
DATE REC'D BY LOCAL REG. OCT 22 1956		REGISTRAR'S SIGNATURE Carl Smith		ADDRESS 2849 N. Euclid Ave.				

FR 12275

Dr. Bowdler

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STATEMENT BY LICENSED EMBALMER

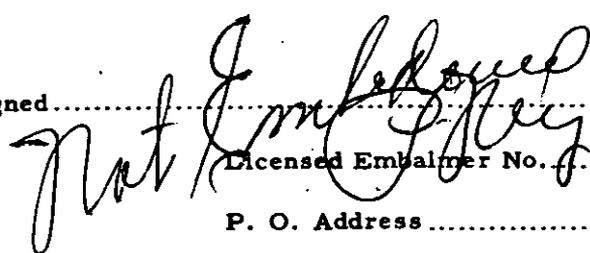
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by, Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....



Licensed Embalmer No.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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

MISSISSIPPI DEPARTMENT OF HEALTH