

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032443
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 122

5. 300.
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Jones</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Martelle</u> <u>814 8</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Holl Hospital</u>			Length of stay in lb <u>1 day</u>		d. STREET ADDRESS (If outside, give location) <u>Do Not Know</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Emanuel</u> Last <u>Mull</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-1918</u>		9. AGE (In years last birthday) <u>40</u>	F UNDER 1 YEAR Months <u>1</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Anthony Mull</u>			13b. MOTHER'S name NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Lucille Mull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <u>Do not know</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Don Axline Martelle Iowa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from lung.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture pelvis, lumber vertebrae, rt humerus & elbow.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Auto-truck accident</u>					
20c. TIME OF INJURY Hour <u>2:30</u> a.m. <u>9/16/58</u> p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>2 1/2 miles S of Bethany Harrison Mo</u>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>Bethany Harrison Mo</u>		COUNTY <u>Harrison</u>		STATE <u>Mo</u>	
21. I attended the deceased from <u>7:45 p.</u> to <u>9:17/58</u> and last saw him alive on <u>9/17/58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) <u>Merriam Gearhart MD. Bethany Mo</u>				22b. ADDRESS <u></u>		22c. DATE SIGNED <u>9/17/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-18-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goettsch Mortuary</u>		23d. LOCATION (City, town, or county) <u>Anamosa Iowa</u>		(State)	
24. FUNERAL DIRECTOR <u>Walter Bethany Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-18-58</u>		26. REGISTRAR'S SIGNATURE <u>Zella Mayes</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OCT 17 1958

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 *WBL Jaos*

Licensed Embalmer No. *3899*

P. O. Address *Bethany, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.