

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032451

STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 133 Primary Registration District No. 5483 Registrar's No. 120

300
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>Lynn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Bethany Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Martelle</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>Highway 69-4 M. South Emin</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Azline</u> Last <u>Mull</u>		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>39</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (City and state or country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Joseph Azline</u>		13b. MOTHER'S MAIDEN NAME <u>Grace Brutsman</u>	
14. NAME OF HUSBAND OR WIFE <u>Homer Mull</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>483-26-6663</u>		17. INFORMANT Address <u>Packet Contents</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>Skull & multiple fractures-Internal Injuries</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Automobile collision with Trailer Truck</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>Automobile Accident with Trailer Truck</u>	
20c. TIME OF INJURY Hour <u>2:30</u> Month, Day, Year <u>9-16-58</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>U.S. 69</u>		20f. CITY, TOWN, OR LOCATION <u>Bethany - Harrison</u> COUNTY <u>Missouri</u> STATE <u>Missouri</u>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>2:30</u> <u>G.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>[Signature]</u> (If free or full) <u>Coroner</u>		22b. ADDRESS <u>Bethany - Missouri</u>	
22c. DATE SIGNED <u>9-17-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>9-17-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Goettsch Fun. Home</u>	
23d. LOCATION (City, town, or country) (State) <u>Anamasa Iowa</u>		24. FUNERAL DIRECTOR <u>MS Haas</u> ADDRESS <u>Bethany, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>9-17-58</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *M. B. Haas*

Licensed Embalmer No. *3899*

P. O. Address *Beth Ann, 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.