

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040806

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 227

Primary Registration District No. 5-804

Registrar's No. 60

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Monroe</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Monroe</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jackson Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Paris</b> 6690
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RFD 3 Paris, Missouri</b>		Length of stay in lbs <b> yrs</b>	d. STREET ADDRESS (If outside, give location) <b>R. F. D. 3</b>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Gerald McCallister Mull</b>			4. DATE OF DEATH Month Day Year <b>Dec. 2 1958</b>		
--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 2, 1890</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 MRS. Hours Min.
-----------------------	----------------------------------	---	---	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Carthage, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	---	---	--

13a. FATHER'S NAME <b>Isaac Mull</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Saylor</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Mull</b>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Florence Mull Paris, Missouri</b>	Address <b>RFD 3</b>
---	--	--	----------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
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)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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:) <b>4201</b>
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

21. I attended the deceased from <b>12-8-58</b> to <b>12-9-58</b> and last saw him alive on <b>12-1-58</b> Death occurred at <b>12:30</b> A. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>Gerald McCallister Mull MD</i>	22b. ADDRESS <i>Paris, Missouri</i>	22c. DATE SIGNED <b>12-9-58</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-4-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mexico, Missouri</b>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Arnold Funeral Home Mexico, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-3-58</b>	26. REGISTRAR'S SIGNATURE <b>J. A. Barnette, D.</b>
--	---------	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Leo H. Whitaker .....

Licensed Embalmer No. 4780.....

P. O. Address Medina, 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.