

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021583

STATE FILE NUMBER 2904

FILED JUN 24 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2904

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF DECEASED (If in hospital, give location) William Mullins		d. STREET ADDRESS 1616 Alice	
3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: FRANK Last: MULLINS		4. DATE OF DEATH Month: June Day: 14 Year: 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A.D.T. Tel. Insp.		10b. KIND OF BUSINESS OR INDUSTRY A.T.T. Co.	11. BIRTHPLACE (City and state or country) Kansas City, Mo.
13a. FATHER'S NAME Thomas Mullins		13b. MOTHER'S MAIDEN NAME Anna Goodhart	14. NAME OF HUSBAND OR WIFE Evelyn Mullins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 486-05-8082	17. INFORMANT William Mullins, Jr. 905 Brookside, K.C., Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-Carcinoma Bronchogenic + mediastinum Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION 1621	
21. I attended the deceased from Jan 26, 1959 to June 14, 1959 and last saw him alive on June 12, 1959 Death occurred at 5:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Frank E. Day, D.O. (Degree or title)		22b. ADDRESS 4314 99th K.C. Mo	
22c. DATE SIGNED 6-15-59		23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-17-59	
24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Independence, Mo.		25. DATE RECD. BY LOCAL REG. 6-15-59	
26. REGISTRAR'S SIGNATURE neva minshall		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frank E. Day

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

Dean W. Huff

Licensed Embalmer No. *4914*

P. O. Address *Indy, 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.