

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023344

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **042**

Primary Registration District No. **1000**

Registrar's No. **729**

STATE FILE NUMBER

FILED JUN 24 1963

VS 300
Rev. 4/59

1 **5117**

2 **5117**

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4 **0**

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12 **86-2**

13 **1-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **N.D. Turney, M.D.** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,		Length of stay in 1b 4 years	c. CITY OR TOWN St. Joseph, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunnyslope Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 513 North 9th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDMUND Middle E. Last MULLIGAN			4. DATE OF DEATH Month June Day 6 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Wholesale Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocer	9. AGE (last birthday) 89 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. FATHER'S NAME Thomas Mulligan		11b. MOTHER'S MAIDEN NAME Ellen McLaughlin	12. CITIZEN-OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE Margaret Ann Mulligan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter Mrs. Joseph Roth-St. Joseph, Missouri		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia Fractured Hip 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 2 days 19 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 Apr. 1963 to June 5 1963 and last saw ^{him} alive on June 5 . Death occurred at 6:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Nelle D. Turney MD		22b. ADDRESS 1314 N-27th St	22c. DATE SIGNED 6-20-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 6, 1963	23c. NAME OF CEMETERY OR CREMATORY Verchelden Funeral Home	23d. LOCATION (City, town, or county) (State) St. Marys, Kansas
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. June 21, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 6-6-63

R 115
R 114
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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,

3-88

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond P. [Signature]

Licensed Embalmer No. 5147

P. O. Address St Joseph Ho

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.