

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6149

1326

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo** (No. **City Hosp. No. 2**)

File No.
 Registered No.
 St. Ward

2. FULL NAME

Georgia Mitchell
 (a) Residence. **1414 Biddle St., 25** Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred **11** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female, Negro** 4. COLOR OR RACE **Married** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Henry Mitchell**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 11, 1885**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 11 22
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **nil**
 (b) General nature of industry, business, or establishment in which employed (or employer) **—**
 (c) Name of employer **—**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT **Mrs. F. Woodard**
 (Address) **City Hospital # 2**

15. FILED **FEB - 7 1927** 19. **Max B. Starkeoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 3 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 30**, 19**27**, to **Feb 3**, 19**27**, that I last saw her alive on **Feb 3 P**, 19**27** and that death occurred, on the date stated above, at **6 P** - m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremic Coma
131
132) B (duration) yrs. mos. ds. **2 ds.**
 CONTRIBUTORY **Chronic Nephritis** (SECONDARY) (duration) **Indefinite**

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH
 DID OPERATION RECORD EXIST? **NO** DATE OF

18. WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & Laboratory**
 (Signed) **J. W. Woodard, M. D.**
 , 19 (Address) **City Hosp. No. 2**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood Cemetery** DATE OF BURIAL **2/7/ 1927**

20. UNDERTAKER **Dunn Bros** ADDRESS **2158 Jefferson Ave**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

