

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

Do not use this space.

10239

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.....

Township.....

Primary Registration District No. **1003**

Registered No. **2827**

City **Springfield Mo** (No. **4201**)

St.

Ward.....

2. FULL NAME **Clarence H Mitchell**

(a) Residence. No. **4201 Cook** St., **11** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Caucasian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Arata Mitchell**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 18 1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 **-** **3**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Chief Cook**
(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) **Mo**

10. NAME OF FATHER **Henry L Mitchell**

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

12. MAIDEN NAME OF MOTHER **Clara Smith**

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

14. INFORMANT **Arata Mitchell**
(Address) **4201 Cook Ave**

15. FILED **1927** **Mar 6 8** **Starceff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-21-27**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 5**, 19**26**, to **March 7**, 19**27**, that I last saw him alive on **March 21**, 19**27**, and that death occurred, on the date stated above, at **10:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
23H Phthisis Pulmonalis

31 (duration)..... yrs. **6** mos. **1** ds.

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **M J P**, M. D.
, 19 (Address) **606 Cornwell St**

*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 **Springfield Mo.** DATE OF BURIAL **3-23-27**

20. UNDERTAKER **W. Wade Orndorff** ADDRESS **4202 Finney**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A VITAL RECORD. 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.

