

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

Do not use this space.

32330

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City *St. Louis Mo.* (No.)

Sanitarium (Ward).....

File No.....

Registered No. *9748*

2. FULL NAME

George Mitchell

(a) Residence. No. *2529 1/2 Jefferson St.*, *13* Ward.

Length of residence in city or town where death occurred *63* yrs. - mos. *6* da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Oct. 25, 1864

7. AGE

YEARS
63

MONTHS
-

DAYS
6

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Stone Polisher

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

14.

INFORMANT (Address)

*R. Kerrill
City Lane*

15.

FILED

Oct 31 1920 Max C. Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

10-30 1920

17.

I HEREBY CERTIFY, That I attended deceased from *May 16*, 19*27*, to *10-20*, 19*27*, that I last saw h. *alive* on *10-28*, 19*27*, and that death occurred, on the date stated above, at *12:20 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic
985 myocarditis*

(duration) yrs. *5* mos. *15* da.

CONTRIBUTORY (SECONDARY)

90 B

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *R. Kerrill*, M. D.

10-30, 1920 (Address) *City Lane*

*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

Calvary Cemetery

DATE OF BURIAL

Nov. 2 1920

20. UNDERTAKER

Wm. Schumacher

ADDRESS

1844 N. Jefferson

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.

PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH

