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

Do not use this space.

X

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1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township Marion — Primary Registration District No. 3029 — Registered No. 9

City Hannibal (No. 814 Sycamore St. 4 Ward)

2. FULL NAME Robert Eugene Mitchell

(a) Residence. No. 814 Sycamore St., 4 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. ds. 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*)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 17, 1928

7. AGE — YEARS — MONTHS: 3 — DAYS: 27 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Delmar V. Mitchell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hannibal (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Clara I. Morgan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Mr. Delmar V. Mitchell (Address) Hannibal Mo.

15. FILED Jan 15, 1929 C. E. Strode M REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-13-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 13, 1929, that I last saw him alive on Jan 28, 1929, and that death occurred, on the date stated above, at 6.9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11 B

(duration) yrs. 6 hrs. ds.

CONTRIBUTORY (SECONDARY)

11 B

(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) A. B. Blue, M. D

, 19 (Address) Hannibal Mo

*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: Mt. Olivet Cemetery — DATE OF BURIAL: 1-15-1929

20. UNDERTAKER: James O'Donnell — ADDRESS: Hannibal Mo

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.