

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

Do not use this space.

17875

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. 791  
 Township \_\_\_\_\_ Primary Registration District No. 11003  
 City St. Louis (No. Pepperdessa) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 5020

**2. FULL NAME**

Mathias Mitchell  
 (a) Residence. No. 2710 Chestnut St. 22 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 10<sup>th</sup> 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
45 8 7

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

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

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Lila Mae Mitchell  
 (Address) 2710 Chestnut

15. FILED May 22 1930 W. C. Harvey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17-1930

17. I HEREBY CERTIFY, That I attended deceased from 5/12, 1930, to 5/17, 1930 that I last saw him alive on 5-16-1930, and that death occurred, on the date stated above, at 4:15 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
10 1/2 (duration) yrs. mos. 10-12 ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
 (Signed) Leo Combs, M. D.  
5/11, 1930 (Address) 2803 Pine

\*State the DISEASES 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 Catholic Burial Cemetery DATE OF BURIAL 5-25 1930

20. UNDERTAKER Catholic Funeral Home ADDRESS 4417 Linney

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MEMORANDUM FOR THE DIRECTOR, FBI  
SUBJECT: [Illegible]

TO: [Illegible]

FROM: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]