

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

Do not use this space.

~~20501~~
20405
Registered No. 113

1. PLACE OF DEATH

County St. Louis Registration District No. 757
Township _____ Primary Registration District No. 3036
City St. Louis (No. St. Joseph's Hospital) St. _____ Ward _____

2. FULL NAME

Ingegrate Mitchell
(a) Residence. No. 709 S. 8th St., _____ 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 Female 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) June 25-1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 1 hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) MO

10. NAME OF FATHER Levil Mitchell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) MO
12. MAIDEN NAME OF MOTHER May Mitchell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Independence, Mo.
(STATE OR COUNTRY) MO

14. INFORMANT Levil Mitchell
(Address) 709 S. 8th St.

15. FILED 6/25/30 Hy. H. Blaisdell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1930

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 25, 1930, that I last saw her alive on June 25, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intracranial hemorrhage due to injury at birth
16DB

CONTRIBUTORY (SECONDARY) 16DB
(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) Ingegrate Mitchell, M. D.
, 19 30 (Address) St. Joseph's 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 Maunterville Mo DATE OF BURIAL Jun 26 1930

20. UNDERTAKER W. Hallmeyer + Sons ADDRESS 60 St. Louis

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.

