

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

Do not use this space.

29616

SEP 24 1930

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 428)

Registration District No. 318
Primary Registration District No. W. Lynn

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 928 W. Lynn St., _____ Ward.

(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)

Widower

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

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

May 16 - 1838

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>92</u>	<u>3</u>	<u>22</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Farmer
(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)

Ill

10. NAME OF FATHER

Mr. P. Mitchell

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

Ch Va. S.

12. MAIDEN NAME OF MOTHER

Elizabeth Edwards

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

Va.

14. INFORMANT (Address)

Bessie A. Mitchell
Springfield, Mo.

15. FILED

9-10, 1930

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1930 to Sep 8 1930 that I last saw him alive on Sep 8 1930 and that death occurred, on the date stated above, at 6:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Bronchitis
106A
162

CONTRIBUTORY (SECONDARY)

senility (duration) _____ yrs. _____ mos. _____ ds.
RAIL (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. D. Barnes, M. D.

*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

DATE OF BURIAL

Green Lawn Cemetery Sep 10 1930

20. UNDERTAKER

ADDRESS

J. W. Klingner & Co
Springfield, Mo.

N. S. Board of Health Missouri State Board of Health. Physicians should state cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important.

[The main body of the document is blank, containing only faint, illegible markings and noise.]

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.
Township Primary Registration District No. 2001 Registered No.
City Springfield St. Ward)

2. FULL NAME

James Mitchell
(a) Residence No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Wid

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

FILED 9/10. 19.30 Loss Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 8 1930

17. I HEREBY CERTIFY That I attended deceased from 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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. D.

, 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. I. 7.—Every item of information should be carefully supplied. A copy should be made of this statement of OCCUPATION is very important. CAUSE OF DEATH should be stated, so that it may be properly classified. EXCEPT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1930
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