

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

Do not use this space.

20418

1. PLACE OF DEATH

County Adair
Township
City Kirkville (No.)

Registration District No. 4
Primary Registration District No. 3001

File No.
Registered No. 121
St. Ward

2. FULL NAME

Amos Mitchell
(a) Residence No. Cottage No. 3 St. Ward
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Hester Mitchell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-30-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>74</u>	<u>2</u>	<u>00</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ret'd Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Boon
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER Malcha Mitchell

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hester Mitchell
(Address) Cottage No. 3

15. FILED 7/13/1931 Mrs C. H. Becker
REGISTRAR

3 D MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-30-1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1931, to June 30, 1931 that I last saw alive on June 29, 1931, and that death occurred, on the date stated above, at 4:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris
94D
 (duration) yrs. 6 mos. ds.
CONTRIBUTORY Heart & Inhalation
(SECONDARY)
of Gas June (duration) yrs. 6 mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) John T. Godson, M. D.
(Address) Kirkville 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 Highland Park **DATE OF BURIAL** 7-3-1931

20. UNDERTAKER Dee Hiley **ADDRESS** Kirkville

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**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 Adair
Township
City Keokuk (No.)

Registration District No. 4
Primary Registration District No. 2001

File No.
Registered No. 121
St. Ward)

2. FULL NAME Cross 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 (write the word) M

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Sept 7, 1931 Mrs. C.H. Beck Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30, 1931

22. I HEREBY CERTIFY, That I attended deceased from ... to ... 19...

I last saw him alive on ... 19... Death is said to have occurred on the day stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

*Amputated Fractured
has been fall - and was
over come by the heat and
framed point gas - in a
falling station where he
worked
Heat and inhalation
of gas fumes*

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

SUPPLEMENTARY

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