

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.

NOV 20 1931

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

Do not use this space.

25889

1. PLACE OF DEATH *Phelps*
 County *Phelps* Registration District No. *677*
 Township *Kalla* Primary Registration District No. *4403*
 City *Kalla* No. _____ St. _____ Ward _____

2. FULL NAME *Byrne Mitchell*
 (a) Residence, No. *St. James* St. _____ Ward. *St. James mo.*
 (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) *July 7, 1922*

7. AGE YEARS *9* MONTHS _____ DAYS *16* 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) *St. James, mo*

FATHER 13. NAME *Sam S Mitchell*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. James, mo*

MOTHER 15. MAIDEN NAME *Sally J Dodds*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Steubenville, mo*

17. INFORMANT *Sally J Dodds* (ADDRESS) *St. James mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Union Cem* DATE *July 24* (3)

19. UNDERTAKER *Jones & Ten Eyck* (ADDRESS) *St. James, mo*

20. FILED *July 24, 1931* *J. F. Ayers* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 23*, 19*31*

22. I HEREBY CERTIFY, That I attended deceased from *July 21*, 19*31*, to *July 23*, 19*31*
 I last saw him alive on *July 21*, 19*31*. Death is said to have occurred on the date stated above, at *12:30 A.M.*
 The principal cause of death and related causes of importance were as follows:
Appendicitis
121B/21
 Date of onset _____

Other contributory causes of importance: _____

Name of operation *Appendectomy* Date of *7/21/31*
 What test confirmed diagnosis? _____ Was there an autopsy? *no*

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) *Richard M. Farland* M. D.
 (Address) _____

