

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

Do not use this space.

1. PLACE OF DEATH

County Macon
Township Hudson
City Frank Mitchell (No. _____)

Registration District No. 533
Primary Registration District No. 0713

31821
File No. _____
Registered No. 89
St. _____ Ward _____

2. FULL NAME

Frank Mitchell

(a) Residence, No. _____ 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>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widower</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Jammie Mitchell</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Ok, 1861</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>Ok</u>
	DAYS <u>Ok</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired</u>	11. Total time (years) spent in this occupation
	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)	

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-24-1931

22. I HEREBY CERTIFY, That I attended deceased from Sp-7 to Sp-24, 1931

I last saw the deceased alive on Sp-24, 1931. Death is said to have occurred on the date stated above, at 5:00 a.m.
The principal cause of death and related causes of importance were as follows:

Sepsis Infection
H.
Date of onset _____
Other contributory causes of importance:
Broken Hip

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

FATHER 13. NAME
Ok,

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

MOTHER 15. MAIDEN NAME
Ok,

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

17. INFORMANT (ADDRESS)
Robert Mitchell
Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE
Oakridge Cem. DATE 9-25-31

19. UNDERTAKER (ADDRESS)
Stephens & Stoddard
Mason, Mo.

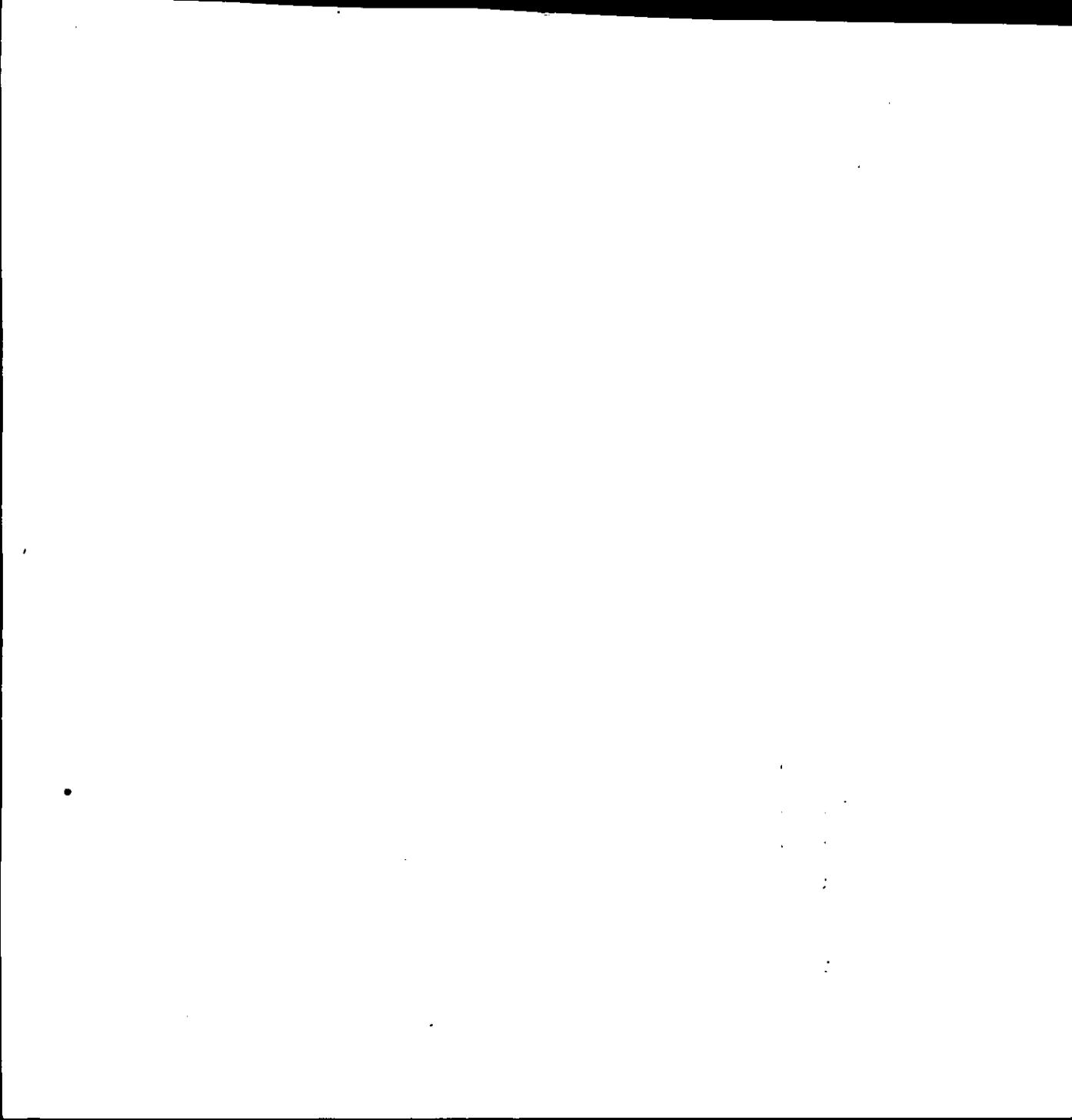
20. FILED 9/31 31 Mrs Luke Hunkler
Registrar

23. 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) A. M. Rivers, M. D.
(Address) Macon



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Macon Registration District No. 9-3-3 File No. _____
 Township Hudson Primary Registration District No. 5-7-3 Registered No. 89
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Frank Gitchel

(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) 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 _____
 (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) _____

15. FILED 11/4 1931 Mrs Luke Hunkler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/24 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 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:

Septic infection

CONTRIBUTORY (SECONDARY) Broken hip (duration) _____ yrs. _____ mos. _____ ds.
Fell while walking (duration) _____ yrs. _____ mos. _____ ds.
in County infirmary
where he died.

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) 1860 _____, 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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1281E-S