

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.

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

Do not use this space.

3528

108  
4  
FEB 25 1932

1. PLACE OF DEATH *Vernon*  
County.....*Vernon*..... Registration District No. *877*  
Township.....*Schell City*..... Primary Registration District No. *45.30*  
City.....*Schell City*..... (No.....)..... St..... Ward.....

2. FULL NAME.....*Lewis Benjamin Mitchem*.....  
(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)

File No. *1-*  
Registered No. *3*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 6 1852*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>79</i>	<i>4</i>	<i>16</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Retired Farmer*

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) *Green Co. Mo. 1*

MOTHER FATHER

13. NAME *James A. Mitchem*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky 2*

15. MAIDEN NAME *Jemima Brashear*

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

17. INFORMANT *Charles Marquis* (ADDRESS)

18. BURIAL, CREMATION OR REMOVAL  
PLACE *Schell City Mo.* DATE *Jan. 23 1932*

19. UNDERTAKER *L. L. Lewis Jr son* (ADDRESS) *Schell City Mo*

20. FILED *1-23-1932* *H. C. Jarvis* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan. 22 1932*

22. I HEREBY CERTIFY, That I attended deceased from *No Physician attending* 19..... to..... 19.....  
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.  
The principal cause of death and related causes of importance were as follows:  
*Carcinoma of Nose and face of five years standing* Date of onset

5 1/2 1/2

Other contributory causes of importance:

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) *No Physician attending*, M. D.  
(Address) *Schell City Mo*

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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 Union  
Township Schell City  
City Schell City (No. \_\_\_\_\_)

Registration District No. 897  
Primary Registration District No. 4530

File No. \_\_\_\_\_  
Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Lewis Benjamin Mitchem

(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.
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OCCUPATION  
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) \_\_\_\_\_

FATHER  
13. NAME \_\_\_\_\_

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

MOTHER  
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 3-18-22 26. G. Jarvis Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22, 1932

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

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

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

Carcinoma of nose and face of jaw and the nose

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation 52 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) \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK. THIS IS A SUPPLEMENTARY RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-5208