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.

791 17809

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 3991

City St. Louis (No. City Hospital St. ..... Ward)

#1563

2. FULL NAME Dr. Charles Mitchell

(a) Residence, No. 2929a No. Newstead St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 30 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): married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 3rd 1868

7. AGE: YEARS 64 MONTHS 7 DAYS 29 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Physician
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) Sioux Falls North Dakota

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hospital Information Grace Kopp City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bloomfield DATE May 4, 1933

19. UNDERTAKER (ADDRESS) J. J. Quinlan 1000 N. Grand Blvd.

20. FILED MAY -3 1933 19 F. Bredecke Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2nd, 1933

22. I HEREBY CERTIFY, That I attended deceased from April 29th, 1933, to May 2nd, 1933

I last saw him alive on May 2nd, 1933. Death is said to have occurred on the date stated above, at 1:15 a.m.

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

	Date of onset
Arterio-Sclerotic Heart Disease (Chronic Myocarditis) 92C	
Acute Cardiac Decompensation 95B	

Other contributory causes of importance: 93C

Name of operation ..... Date of .....

What test confirmed diagnosis? Clin 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? No

If so, specify .....

(Signed) J. McLennan, M. D.

(Address) City Hospital