

OCT 23 1935

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

Do not use this space.

29266

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 2001 Registered No. 442
City Springfield (No. Baptist Hospital) (Ward) _____

2. FULL NAME Baby Leon Mitchell

(a) Residence, No. Reed Springs Ward Two
(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) Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 3, 1934
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 1 2 16

OCCUPATION

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

FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
13. NAME Leathan Mitchell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

MOTHER

15. MAIDEN NAME Mary Morgan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Leathan Mitchell
Reed Springs mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Reed Springs DATE Apr 19 1935

19. UNDERTAKER (ADDRESS) Elizabeth J. J.
244 West

20. FILED 9-19-1935 Reed Springs
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-19-1935
22. I HEREBY CERTIFY, That I attended deceased from 9-18-1935 to 9-19-1935
I last saw him alive on 9-18-1935. Death is said to have occurred on the date stated above, at 3408 ft.

The principal cause of death and related causes of importance were as follows:
Dyscolitis
Anhydremia intoxication
Toxic Encephalitis
Other contributory causes of importance
Purulent otitis media

Date of onset
9-8-35
9-16-35
9-16-35

Name of operation None Date of _____
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? no
If so, specify _____
(Signed) Urban B. Busick, M. D.
(Address) Springfield mo

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.

