

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

NOV 21 1935

32692

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Frank Primary Registration District No. 1002  
 City Kansas (No. General Hospital # 1, St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

(a) Residence, No. 1518 Tracy 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 male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 18, 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
39 7 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janitor  
 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) Arkansas

FATHER 13. NAME Columbus Mitchell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

MOTHER 15. MAIDEN NAME Mittie Duncan

15. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

17. INFORMANT Mittie Harris

(ADDRESS) 1518 Tracy

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 11/10 1935

19. UNDERTAKER Hatkins Bros

(ADDRESS) 1729 1/2 W. 4th

20. FILED 10/10 1935 M. M. Corum Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-5, 1935

22. I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1935 to Oct. 5, 1935

I last saw him alive on Oct. 5, 1935. Death is said to have occurred on the date stated above, at 8:25 a.m.

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

Apoplexy

Other contributory causes of importance:

Hypertension (malnutrition)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis skinner Was there an autopsy yes

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) General Hos. # 2

