

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

33001
Do not use this space.

1. PLACE OF DEATH *00124-337*

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis, Missouri** (d) Street No. **5351 Delmar Blvd. (Masonic Hospital)** St. **9055**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **10** yrs. **3** mos. **1** ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Robert C. Mitchell**

(a) Residence, No. **5351 Delmar Blvd.** St. **12**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 7, 1849**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>67</i>	88	1	21	

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

9. Industry or business in which work was done, as law mill, bank, etc. **Retired**

10. Date deceased last worked at this occupation (month and year) **Abt. 1920** 11. Total time (year) spent in this occupation **45 Yrs**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

FATHER 13. NAME **(Unknown) Mitchell**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Elizabeth Wright**

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

17. INFORMANT (ADDRESS) **Mrs. W. Waller**
5351 Delmar Blvd. St. Louis, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE **LaPlata, Mo.** DATE **Sept. 30th, 1937**

19. FUNERAL DIRECTOR **Albert H. Hoppe Inc.**
(ADDRESS) **429 N. Euclid Avenue**

20. FILE **SEP 28 1937** *J. Bredeck*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **September 28, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **August 29, 1928** to **September 28, 1937**
 I last saw him alive on **September 27, 1937** Death is said to have occurred on the date stated above, at **6, 50 A. M.**
 The principal cause of death and related causes of importance were as follows:

Chronic Valvular Heart Disease	Date of onset 2yrs.
Senility	1 yr.

Other contributory causes of importance: *9/2 a*

Name of operation Date of
 What test confirmed diagnosis? **Phy. Ex.** 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 **Colon Cancer**, M. D.
 (Signed) *Colon Cancer*
 (Address) **Mayropolitan Bldg.**

(Licensed Embalmer's Statement on Reverse Side)

MARG. RESERVED FOR BINDING
 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.
 V. S. O. 2. 50M-7-20-37 I X12004

STATEMENT BY LICENSED EMBALMER

I, Albert H. Hoppa, Licensed Embalmer No. 1861
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me
L. E.
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.
Signed Albert H. Hoppa
Licensed Embalmer No. 1861

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)