

NOV 15 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35787
Do not use this space.1. PLACE OF DEATH **Homer G Phillips Hospital**

(a) County

Registration District No.

(b) Township

Primary Registration District No.

(c) City **Saint Louis**(d) Street No. **2601****N Whittier**Registered No. **9364**(e) Length of residence in city or town where death occurred **2** yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.2. PRINT FULL NAME **Jim Mitchell**(a) Residence, No. **3106 Magazine**St. **17**

(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

M

4. COLOR OR RACE

C

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

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

unknown

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

Nov. 25, 1881

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

55**10****5**

OCCUPATION

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

Farmer

9. Industry or business in which work was done, as 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)

Mississippi

MOTHER

13. NAME

John Mitchell

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

Mississippi

15. MAIDEN NAME

unknown

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

Mississippi

17. INFORMANT (ADDRESS)

Evelyn Hilliard**2601 N. Whittier**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Washington** DATE **Oct 7 1937**

19. FUNERAL DIRECTOR (ADDRESS)

James L. Lewis**2039 Olive St.**

20. OCT 7 1937

1937**James L. Lewis**

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 30**, 19 **37**22. I HEREBY CERTIFY, That I attended deceased from **Aug. 27**, 19 **37** to **Sept. 30**, 19 **37**I last saw him alive on **Sept. 30**, 19 **37**. Death is saidto have occurred on the date stated above, at **3:40** m. **p.m.**

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

Arteriosclerotic Heart Disease

Date of onset

9/27**37**

Other contributory causes of importance:

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

What test confirmed diagnosis? **clinical**. 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?.....

If so, specify.....

(Signed) **A. L. Lewis**

(Address)

2601 N Whittier

, M. D.

STATEMENT BY LICENSED EMBALMER

I, Robert H. Powell

Licensed Embalmer No. 3402

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Robert H. Powell

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed

Robert H. Powell

Licensed Embalmer No. 3402

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.)