REC'D MAY 10 1939

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

791
1003

13271
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 3613

(c) or City Saint Louis (d) Street No. Homer G. Phillips Hospital St.
(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 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

3211

2. PRINT FULL NAME John Mitchell

(a) Residence, No. 4353a West Belle Place St. //
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Negro	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unavailable 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	65	—	—	

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc. Apartments

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 6

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison County Missouri

FATHER

13. NAME Unavailable

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

MOTHER

15. MAIDEN NAME Ellen--Unknown

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

17. INFORMANT Mrs Ella Mitchell
(ADDRESS) 4353a West Belle Place

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE 4-19-39 19

19. FUNERAL DIRECTOR (NAME) Charles J. Gates
(ADDRESS) 4107-09 Finney Avenue

20. FILED APR 19 1939 19 J. B. Buchek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 17th, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 13, 1939, to April 17th, 1939
I last saw him alive on April 17th, 1939. Death is said to have occurred on the date stated above, at 8:48 m. a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	3/13/39
Arteriosclerosis	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical 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? No
If so, specify .....
(Signed) H. J. Lyman, M. D.
(Address) Homer G. Phillips Hosp.

(Licensed Embalmer's Statement on Reverse Side)

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.

X16503

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by James A. Johnson, Registered Apprentice No. _____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave

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.)

If this body is not embalmed, above space should be left blank.