. No. 2
-11-10-39
5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36932

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9205

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. ~~Louis~~

(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2825a Laclede
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mitchell, Ethel

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex F

5. Color or race C

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Oliver Mitchell

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Dec. (Month) 25 (Day) 1897 (Year)

8. AGE: ~~46~~ Years 42 Months 10 Days 9 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Kapp Stallon
13. Birthplace Lebanon (City, town, or county) mo (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Oliver Mitchell
(b) Address 2825 Laclede ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/40 (Month) (Day) (Year)
(c) Place: burial or cremation Lebanon Missouri

18. (a) Signature of funeral director C. W. Roberts
(b) Address 3035 Lucas ave

19. (a) NOV 8 1940 (Date received local registrar) (b) J. E. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4
year 1940 hour 6 minute 28 A. M.

21. I hereby certify that I attended the deceased from Nov. 2, 1940 to Nov. 4, 1940
that I last saw her alive on Nov 4, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Rt. Cerebral Hemorrhage

Due to Chronic Glomerulo Nephritis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Rt. cerebral Hemorrhage
Cerebral Arteriosclerosis, Nephrosclerosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J. F. Davis (M. D. or other) Vice
Address St. Mary's Infirmary Date signed 11-5-40

(Licensed Embalmer's Statement on Reverse Side)

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 me Chas. Gaines, Registered Apprentice No. 2349 working under my personal supervision.

Signed Chas. Gaines

Licensed Embalmer No. 2349

P. O. Address

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.