

FILED APR 28 1941
Registration District No. **386**

Primary Registration District No. **538**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newell Benton Twp**
(b) City or town **Acacoo Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Ergebnie Mitchell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **Child**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive **36** years

7. Birth date of deceased **4-24-1904**
(Month) (Day) (Year)

8. AGE:

4 Years **10** Months **8** Days If less than one day hr. min.

9. Birthplace

Acacoo Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

Child

11. Industry of business

MOTHER FATHER

12. Name **Rayon F. Mitchell**

18. Birthplace **Bakersfield Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Gerda K. Wirth**

15. Birthplace **Acacoo Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **M. F. Mitchell**

(b) Address **Acacoo Mo**

17. (a) **Burial**

(b) Date thereof **3-13-41**
(Month) (Day) (Year)

(c) Place of burial or cremation **Country**

18. (a) Signature of funeral director **Robert W. ...**

(b) Address **W. H. ... Mo**

19. (a) **3-5-41**

(b) **Vida W. Simons**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Newell**
(c) City or town **Acacoo Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **2** P.
year **1941** hour **10** minute **30** M.

21. I hereby certify that I attended the deceased from **2-29** to **3-2** 19**41** and that death occurred on the date and hour stated above.

that I last saw him alive on **3-2** 19**41**
Immediate cause of death **Doubt bronchial pneumonia**
Duration **4 days**

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **C. A. Beach** (M. D. or other) **M.D.**
Address **Acacoo Mo** Date signed **3-5-41**

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

2004

107

RECEIVED

District Health Officer No. 5,

District File Number. 441484

Date Filed _____

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10839

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 386

Primary Registration District No. 3538

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Benton T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Eugene Mitchell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced other

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 4 Months 10 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 2 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Double bronchial pneumonia
Due to no previous sickness

Due to _____
Other conditions (Include pregnancy within 3 months of death) 107

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature C.A. Beach (M. D. or other) JMB
Address Elijah me Date signed 3-2

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

SUPPLEMENTARY

1941
S-10839