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7-39
X23159

FILED JUL 7 1941

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Jackson City

(c) Name of hospital or institution: Northwest Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 5-5-41 to 6-3-41
(Specify whether years, months or days) 30 years 28 days

3. (a) PRINT FULL NAME Signa Augusta Mitchell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color of race Wh

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

6. (b) Name of husband or wife Frank H Mitchell

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Apr. 18, 1892
(Month) (Day) (Year)

8. AGE: Years 49 Months 1 Days 15
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Fundquist

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

14. Maiden name _____

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

16. (a) Informant Frank H Mitchell

(b) Address 616 Hattie, K.C. Mo.

17. (a) Burial (b) Date thereof June 5 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove

18. (a) Signature of funeral director W. O. Speck

(b) Address Independence, Mo.

19. (a) 6/17/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Jackson City, Mo. Wm. Washington
(If outside city or town limits, write "RURAL")

(d) Street No. 618 Hattie St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3rd day June
year 1941, hour 12.45 minute A. _____ M. _____

21. I hereby certify that I attended the deceased from July 19 40 to June 3rd 1941, 19 _____;
that I last saw her alive on June 2nd 1941, 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure.

Duration 2 weeks

Due to Chronic chest infection with lung fibrosis and pleural effusion

Due to Possible tuberculosis altho Tubercle bacilli were not found.

Other conditions None 13 K

(Include pregnancy within 3 months of death)

Pulmonary Tuberculosis (Clin. Diag) PHYSICIAN

Major findings: Right chest full of serous fluid with lung collapse

Of autopsy None

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) NO

(b) Date of occurrence NO

(c) Where did injury occur? NO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
NO (Specify type of place)

While at work? NO (Specify type of place)

23. Signature L. A. Marty (M.D. or other)
Address 815 Mcgee Date signed 6/19/41

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

....., Registered Apprentice No.....
working under my personal supervision.

Signed Roland R. Speaks
Licensed Embalmer No. 3604
P. O. Address Independence

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 39.9

Primary Registration District No. 1002

Registrar's No. 2178

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Signa Augusta Mitchell

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

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

8. AGE: Years 49 Months Days 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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4/27/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

DEATH CERTIFICATION

20. DATE OF DEATH Month June day 3rd
year 1941 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
Pulmonary tuberculosis 7 yrs

Due to.....

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1381

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

MOTHER FATHER

20648