

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

1917-39  
1-19151

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

37521

1941  
1941

Registration District No. 399

Primary Registration District No. 1002

State File No. \_\_\_\_\_

Registrar's No. 4316

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:  
4434 Forest Avenue  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 40 Years  
years, months or days)

8. (a) PRINT FULL NAME Erasmus Maniferd Mitchell

8. (b) If veteran, name war No

8. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Dottie Lee Mitchell

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased March 24 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74	7	26	hr. min.
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9. Birthplace Near St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Route - Retired

11. Industry or business Kansas City Star

MOTHER FATHER

12. Name Unknown Mitchell

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Dottie Lee Mitchell

(b) Address 4434 Forest Hill

17. (a) Burial (b) Date thereof Nov. 21, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 11-21-41 (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 Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 4434 Forest Avenue  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th  
year 1941 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from Nov 17-41  
\_\_\_\_\_, 19\_\_\_\_, to Nov 19, 1941;  
that I last saw him alive on Nov 19, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema Duration 2 days

Due to Chronic Nephritis South Kansas

Other conditions Cancer of nose & face South Kansas  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 0

23. Signature J. E. Ball (M. D. or other) \_\_\_\_\_  
Address 1110 2 E 47 Date signed 11/20/41

4700 V. ...  
... of Health ...

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**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

*C. Hervey Dusenberry*

Licensed Embalmer No.

4070

P. O. Address

R. C. Mo

**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. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **4316**

1. PLACE OF DEATH:

(a) County .....

(b) City or town .....

(c) Name of hospital or institution:  
**4434 Forest Ave.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution .....

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State .....

(b) County .....

(c) City or town .....

(d) Street No. ....

(e) Citizen of foreign country? .....

3. (a) PRINT FULL NAME **Erasmus Maniferd Mitchell**

3. (b) If veteran, name war .....

3. (c) Social Security No. ....

4. Sex .....

5. Color or race .....

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

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

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

7. Birth date of deceased .....

8. AGE:	Years	Months	Days	If less than one day
	<b>74</b>			.....

9. Birthplace .....

10. Usual occupation .....

11. Industry or business .....

12. Name .....

13. Birthplace .....

14. Maiden name .....

15. Birthplace .....

16. (a) Informant .....

(b) Address .....

17. (a) .....

(b) Date thereof .....

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

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

(b) Address .....

19. (a) .....

(b) .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **17**  
year **1941** hour ..... minute ..... M.

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

Immediate cause of death  
**Pulmonary Edema**

Due to **Chronic Nephritis**

Due to .....

Other conditions **Cancer of nose and face**  
(Include pregnancy within 3 months of death)

*The nose was primary*  
Major findings: *rest of cancer*  
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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? .....

23. Signature .....

Address .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-37521

**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 complete 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

State File No. 375 21

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Jackson City  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

**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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Thomas M. Mitchell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12, Day 24, Year 1966  
hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

4. Sex M 5. Color or race W.

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Mar. 24, 1886  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Due to Primary head-face

Due to \_\_\_\_\_

**8. AGE:** Years 74 Months 7 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

**MOTHER FATHER** { 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)

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? \_\_\_\_\_

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)

While at work? \_\_\_\_\_  
(Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. E. Baer (M. D. or other) \_\_\_\_\_

Address 1102 E. 47 Date signed 1/25/67

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

**SUPPLEMENTARY**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.