S. No. 2
1—1-4-41
. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 14 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 155300

Registration District No. 1 Ff Primary Registration District No. 200 Registrar's No. 990

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 mos 25 days (Specify whether

In this community ~~4 years~~
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 1215 No 21st Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Allen Mitchell

3. (b) If veteran, name war

3. (c) Social Security No. 490-14-8466

4. Sex male

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 9. (Day) 1914 (Year)

8. AGE: Years 28 | Months — | Days 23 | If less than one day hr. min.

9. Birthplace New Madrid (City, town, or county) Mo (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business

FATHER
12. Name Ollie Mitchell
13. Birthplace (City, town, or county) Missouri (State or foreign country)

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

16. (a) Informant Hospital Record
(b) Address Koch, Mo.

17. (a) ~~(Burial, cremation, or removal)~~ (b) Date thereof 5-5-42 (Month) (Day) (Year)
(c) Place: burial or cremation City Hosp. Morgue

18. (a) Signature of funeral director City of St Louis
(b) Address T. G. White, morgue keeper

19. (a) MAY 5 1942 (Date received local registrar) (b) C. G. McGovern MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1942 hour 11 minute 25 A.M.

21. I hereby certify that I attended the deceased from July 8, 1941, to May 2, 1942 that I last saw him alive on May 2, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Hemoptysis

Due to Pulmonary tuberculosis

Due to

Other conditions Intestinal tuberculosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: Questionable

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 Franz U. Steinberg (M. D. or other) M.D.
Address Robert Koch Hospital Date signed 5-2-42

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(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.....

....., 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, fact should be so stated above.