

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 295Primary Registration District No. 4179Registrar's No. 13

1. PLACE OF DEATH: Franklin  
 (a) County Franklin  
 (b) City or town Sullivan  
 (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 2 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED: 36  
 (a) State Missouri (b) County Franklin  
 (c) City or town Sullivan 4  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME SARAH T. MITCHELL

3. (b) If veteran, name war  No. \_\_\_\_\_  
 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 James L. Mitchell 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased July - 20 - 1872  
 (Month) (Day) (Year)

8. AGE: 69 Years 11 Months 4 Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo. 0  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Berry Barnett

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

14. Maiden name Nancy Russell

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

16. (a) Informant Caroline Stephens

(b) Address Shelbourn Mo.

17. (a) Burial (b) Date thereof 6-27-42  
 (Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Bourbon Mo.

18. (a) Signature of funeral director Elbert Long

(b) Address Bourbon Mo.

19. (a) 6-27-42 (b) Sullivan  
 (Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Unknown

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) \_\_\_\_\_  
 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

23. Signature D. L. Garner or other \_\_\_\_\_

Address Sullivan Mo. Date signed 6/27/42

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

*Elbert Edging*

Licensed Embalmer No.

*3504*

P.O. Address

*Bourbon, 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. 21140

Registration District No. 295

Primary Registration District No. 4179

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

1. PLACE OF DEATH:

(a) County Franklin  
Sullivan

(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_  
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 Sarah J. Mitchell

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day \_\_\_\_\_ year 1942 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 \_\_\_\_\_

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 July 26-1873  
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

Due to Chronic Hypertensio

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

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

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

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

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)

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 D. P. Barnes \_\_\_\_\_ (or other) \_\_\_\_\_  
Address Sullivan Mo. Date signed 8/2/42

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

