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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22457  
Registrar's No. 1391

Registration District No. 217

Primary Registration District No. 6076

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

26000

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch

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

(d) Length of stay: In hospital or institution 6 mos.  
(Specify whether years, months or days)

In this community 9 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mitchell, Andrew

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

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

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 Nov. 10 1916  
(Month) (Day) (Year)

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

26 7 1 hr. \_\_\_\_\_ min.

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

10. Usual occupation nil

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

MOTHER FATHER

12. Name Charles Mitchell

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

14. Maiden name Katie Danberroy

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

16. (a) Informant patient on entry to hospital

(b) Address Koch Hos, Koch MO

17. (a) Removal (b) Date thereof 6-13-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HUNTER, Ark

18. (a) Signature of funeral director Ellis Fun Home

(b) Address 2820 Standard St

19. (a) JUN 16 1943 (b) E. J. McRaven, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 10

(c) City or town St. Louis 9  
(If outside city or town limits, write "RURAL.")

(d) Street No. 4211 W. Easton  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11  
year 1943 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from 12/4/42, 19\_\_\_\_, to 6/11, 1943,  
that I last saw im alive on 6/10/43, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis 1 yr?  
Duration

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

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

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

Major findings: 1361

Of operations \_\_\_\_\_

Of autopsy none done

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) none

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

23. Signature W. J. ... M.D. (M. D. or other)  
Address Koch Hospital, Koch, Mo Date signed 6/11/43

**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 L Boykin  
....., Registered Apprentice No. IM  
working under my personal supervision.

Signed

Lennie Boykin

Licensed Embalmer No. 2946

P. O. Address St Louis 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, fact should be so stated above.**