

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED AUG 10 1943

Registration District No. 8

Primary Registration District No. 8006

Registrar's No. 162

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: l x x  
(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 5 yr (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Robert Glenn Mitchell

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Male

5. Color or race W

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

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

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

7. Birth date of deceased Sept 2 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>9</u>	<u>29</u>	_____ hr. _____ min.

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

10. Usual occupation Retired Merchant

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

MOTHER FATHER { 12. Name James Wm Mitchell

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

14. Maiden name Mary Ann Glenn

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

16. (a) Informant Mrs Luna Mitchell

(b) Address Columbia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

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

(b) Address Columbia Mo

19. (a) 7-4-1943 (Date received local registrar) (b) E. O. H. Barber (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Columbia  
(If outside city or town limits, write "RURAL")

(d) Street No. 408 Price av  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st  
year 1943 hour 5 45 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Jan 5, 1942 to June 25, 1943  
that I last saw h. alive on June 19, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Persistent locomotory collapse

Due to metastases

Due to Carcinoma of Prostate gland

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

Major findings: Of operations 51 f

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 H. In Carl Gray (M.D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed July 4 1943

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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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.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signed *R. Oliver* .....

..... Licensed Embalmer No. *3183* .....

*W. E.* 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.**