

FILED FEB 4 1944

STANDARD CERTIFICATE OF DEATH

State File No. 837

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County _____
(b) City or town St Louis
(c) Name of hospital or institution 2411 Belle Glade
(d) Length of stay: In hospital or institution _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis (d) Street No. 2411 Belle Glade
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME Charles Mitchell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 25
year 1944 hour 2 minute _____ A. M.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Mitchell 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Unknown 1865

21. I hereby certify that I attended the deceased from January 14, 1944 to January 25, 1944
that I last saw him alive on January 25, 1944
and that death occurred on the date and hour stated above.

8. AGE: alt-78 Years Months Days If less than one day
hr. min.

Immediate cause of death Bilateral Apical Pul. Tuberculosis
Duration Unknown

9. Birthplace Carroll Mississippi

Due to _____
Due to _____
Other conditions _____

10. Usual occupation Laborer

Major findings: _____

11. Industry or business _____

Of operations _____

12. Name Charles Mitchell

Of autopsy _____

13. Birthplace Unknown

14. Maiden name Mary ?

15. Birthplace Unknown

16. (a) Informant Mary Mitchell

(b) Address 2411 Belle Glade

17. (a) Burial (b) Date thereof Jan. 29 1944

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Russell Untd. Co.

(b) Address 2732 Pine St

19. (a) JAN 27 1944 (b) J. F. Predeck

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) Means of injury _____
23. Signature A. E. Smith (M. D. or _____)
Address 2601 N Whittier St Date signed 1-26-44

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

MOTHER FATHER

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..... *Joel Russell*

Licensed Embalmer No. *7112*

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.