

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

FILED FEB 27 1944 318

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer G. Phillips Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days  
(Specify whether years, months or days) 23 years

3. (a) PRINT FULL NAME Della Mitchell

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced, Widowed

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

7. Birth date of deceased Aug. 10, 1889  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	4	27	hr. min.

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

10. Usual occupation Nil.

11. Industry or business

MOTHER FATHER

12. Name Stock Crocker

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

14. Maiden name Rose Davis

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

16. (a) Informant Cornelia's Monroe  
(b) Address 3429 Laclede, Ave.

17. (a) Burial (b) Date thereof 1/13/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Wrights Funeral Home  
(b) Address 3100 Easton Ave.

19. (a) JAN 13 1944 (b) J. E. Smith (c) Registrar's signature  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
12

(c) City or town St. Louis, Mo. 921  
(If outside city or town limits, write "RURAL")

(d) Street No. 3429 Laclede  
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7,  
year 1944 hour 8 minute 48 A.M.

21. I hereby certify that I attended the deceased from December 23, 1944 to January 7, 1944  
that I last saw her alive on January 7, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Right Lobar Pneumonia 3 weeks  
Duration

Due to

Due to

Other conditions: 108  
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury

23. Signature J. E. Smith (M. D. or other)  
Address 3401 Washington Date signed 1/7/44

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..... *Arthur L. Hillier* .....

Licensed Embalmer No. *4221* .....

P. O. Address *4219<sup>2</sup> E Garfield* .....

**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.**