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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No. 728
Registrar's No. 263

Registration District No. 218

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(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: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 3702 Ohio Ave. 924
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Jacob Mitchell

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rose 6. (c) Age of husband or wife if alive 75 yrs
7. Birth date of deceased November 28 1860
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 12 If less than one day hr. min.

9. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Brewery Work Retired

11. Industry or business

MOTHER FATHER { 12. Name Jacob Mitchell
13. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)
14. Maiden name Dont Know
15. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant John B. Mitchell
(b) Address 5341 Lindenwood Ave.

17. (a) Burial (b) Date thereof January 12, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director John H. Stetten Sons
(b) Address 2630 Gravois Ave.

19. (a) JAN 10 1944 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1944 hour 6:10 minute P M.

21. I hereby certify that I attended the deceased from January 3 19 44 to January 9 19 44
that I last saw him alive on January 9 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Due to 108
Due to Septic
Other conditions (Include pregnancy within 3 months) Septic

Major findings: Of operations Not done
Of autopsy Not done

Duration
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? (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 Frank J. Lange (M. D. or other) MD
Address 1515 Lafayette Avenue Date signed 1/10/44

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 Robert T. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Kravis

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.