

19326

State File No. _____

Registrar's No. 5DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHRegistration District No. 251Primary Registration District No. 6186

1. PLACE OF DEATH:

(a) County Taney
 (b) City or town Brownbranch, Beaver Jct.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community One Hour
 years, months or days

3. (a) PRINT FULL NAME Wilda Mae Mitchell3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 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 May 12 1944
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
3 hr. _____ min.

9. Birthplace Brownbranch, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Claude Mitchell
 { 13. Birthplace McClurg, Missouri
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Leora Humbyrd
 { 15. Birthplace Thornfield Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Claude Mitchell
(b) Address Brownbranch, Missouri

17. (a) Burial (b) Date thereof 5-13-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Bethel

18. (a) Signature of funeral director Friends
 (b) Address Brownbranch, Missouri

19. (a) 5/17/44 (b) Louise H. Smith
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Taney
 (c) City or town Brownbranch, Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
 year 1944 hour 4 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Mary J. K. Moman (M. D. or other) midwife
 Address Brownbranch, Mo. Date signed May 15 1944

1310 (Licensed Embalmer's Statement on Reverse)

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

No. 2
-8-43
17-39
X37823

FILED MAY 24 1944

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..... *H. B. Hutchinson*

..... Licensed Embalmer No. *3431*

P. O. Address..... *Arva Md*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 5

Registration District No. 351 Primary Registration District No. 6186

1. PLACE OF DEATH:
(a) County Janey
(b) City or town Beary Jump Brownbark
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May 12 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.
9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation
11. Industry or business
12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....
19. (a) (Date received local registrar) (b) Louise Forsyth (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... year..... hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Probable cause of death death patent
Due to.....
Due to foremen scale
Other conditions..... (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION
TESTED
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 Louise Forsyth, R.N. (Date or other)
Address Forsyth, Mo. Date signed 6/2/44

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

SUPPLEMENTARY No. 1572

19326