

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 13 1944**

MISSOURI STATE BOARD OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

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

Registration District No. 279

Primary Registration District No. 5956

Registrar's No. 19

**1. PLACE OF DEATH:** Pike  
 (a) County Pike  
 (b) City or town Country Rural Calumet  
 (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 Missouri (b) County Pike 82  
 (c) City or town Rural 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

**3. (a) PRINT FULL NAME:** Frances Mitchel  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Sept day 6th year 1944 hour 9 minute 30 P. M.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced, widowed  
 6. (c) Age of husband or wife if alive DEB. years

21. I hereby certify that I attended the deceased from May 31 1944 to Sept 6 1944  
 that I last saw her alive on Sept 6 1944  
 and that death occurred on the date and hour stated above.

7. Birth date of deceased Oct. 30 1872  
 (Month) (Day) (Year)  
 8. AGE: Years 71 Months 10 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of biliary tract  
 Duration 10 to 11 mo  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace Troy Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation house wife

Other conditions Profound jaundice with profuse hemorrhage from  
 (Include pregnancy within 3 months of death)  
 Major findings: arrows dentures

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name Synk Sullivan  
 13. Birthplace Troy Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Frances Hall  
 15. Birthplace Troy Mo.  
 (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Of autopsy \_\_\_\_\_

16. (a) Informant Devold Mitchel  
 (b) Address Clarksville Mo.  
 17. (a) Winfield Mo. (b) Date thereof 9/9 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**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? \_\_\_\_\_

(c) Place: burial or cremation Winfield Mo.  
 18. (a) Signature of funeral director L. Brown  
 (b) Address Clarksville Mo.  
 19. (a) Sept 9 1944 (b) Maudie M. Patton  
 (Date of local registration) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature Samuel Buchanan (M. D. or other) DO  
 Address Clarksville Mo. Date signed 9/8/44

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

RECEIVED

District Health Officer No. 10

District File Number 10-44-125

Date Filed OCT-1-1944

**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.....

I.H. Brown

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

working under my personal supervision.

Signed.....

*I.H. Brown*

Licensed Embalmer No. 2648

P. O. Address Clarksville Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 279 Primary Registration District No. 5956

1. PLACE OF DEATH:

(a) County Pike  
 (b) City or town Rural Calumet Twp  
(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)

3. (a) PRINT FULL NAME Frances 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 W  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased Oct 30  
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 10 If less than one day..... min.

9. Birthplace Mo.  
(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)..... (b) Date thereof.....  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a)..... (b).....  
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 19 Year 1968 hour 12 minute 00 M.  
 21. I hereby certify that I attended the deceased from 1968 19.....  
 that I last saw h..... alive on..... 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration.....

Due to.....

Due to.....

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

PHYSICIAN

Major findings:  
 Of operations.....  
 Of autopsy.....  
 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..... (M. D. or other).....  
 Address..... Date signed.....

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

SUPPLEMENTARY

31522