

S. No. 2
M-8-43
v. 5-17-39
W-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3514

State File No. _____

FILED FEB 13 1945

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 2824

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town North Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 weeks 2 days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 5228 Putzer
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MITCHELL, George

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

4. Sex m 5. Color or race col 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Vingues (formerly) Givans 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 8 1897
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 6 If less than one day
hr. _____ min. _____

9. Birthplace LEXA Tex (City, town, or county) (State or foreign country) 1

10. Usual occupation Porter

11. Industry or business _____

MOTHER FATHER

12. Name mit Mitchell
13. Birthplace Tennessee (City, town, or county) (State or foreign country) 1
14. Maiden name Carrie Wilbur
15. Birthplace Texas (City, town, or county) (State or foreign country) 1

16. (a) Informant Robert Koch Hospital Records

(b) Address Koch mo

17. (a) Burial (b) Date thereof 1-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Subington Park

18. (a) Signature of funeral director [Signature]

(b) Address 100321 [Address]

19. (a) 1/18/45 (b) E. S. Mahan (Registrar's signature) _____
(Date received local registrar) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14
year 1945 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 12 1944 to January 14 1945;
that I last saw him alive on January 13 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Duration 13 years

Due to _____
Due to 13 & 1

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

Major findings:
Of operations _____
Of autopsy _____

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 _____
Signature Paul Murphy (M. D. or other) _____
Address _____ Date signed _____

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

FEB 16 1945

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed Clark Young
Licensed Embalmer No. 3371
P. O. Address St Louis

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.