V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25059

FILED AUG 11 1945

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 459

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Ferguson (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Hallsferry Memorial Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 6 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson (If outside city or town limits, write "RURAL")

(d) Street No. 60 N. Harvey (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Louise 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 Widowed

6. (b) Name of husband or wife John Edward Mitchell

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

7. Birth date of deceased Sept. (Month) 22. (Day) 1874 (Year)

8. AGE: Years 70 Months 10 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William B. Mouser
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Amanda Spalding
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs W. A. Holtshouser

(b) Address Ferguson, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/8/45. (Month) (Day) (Year)

(c) Place: burial or cremation Owensboro, Kentucky

18. (a) Signature of funeral director White Funeral Home

(b) Address Ferguson, Missouri

19. (a) 8-7-45 (Date received local registrar) (b) E. G. McGovern (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 7 year 1945 hour 1 minute 15A M.

21. I hereby certify that I attended the deceased from May 16 1945 to Aug 7 1945 that I last saw her alive on Aug 7 1945 and that death occurred on the date and hour stated above.

Immediate cause of death My + Cardiac and Chronic Bronical

Due to Asmuthia

Due to — 93d.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

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) No

(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? — (Specify type of place)

While at work? — (e) Means of injury —

23. Signature Nellie Sleaver (M. D. or other)

Address Tendell Trust Bldg Date signed 8-7-45

(Licensed Embalmer's Statement on Reverse Side)

SEP 20 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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3973

P. O. Address.....

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.