

**FILED** JAN 28 1946  
Registration District No. **273**

Primary Registration District No. **443**

Registrar's No. **44**

1. PLACE OF DEATH:

(a) County **Randolph**

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

(c) Name of hospital or institution: **1**

(If not in hospital or institution, write street number or location)

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

In this community **20 yrs**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Randolph**

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

(d) Street No. \_\_\_\_\_ (If rural, give location) **0**

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **WM ISAACS MIKEL**

3. (b) If veteran, name war **V**

3. (c) Social Security No. **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **13**  
year **1945** hour **3** minute **30** M.

4. Sex **M (1)**

5. Color or race **W.**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **ELLA MIKEL**

6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **MAR 27 1867**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 1**, 19**43** to **Dec**, 19**45**  
that I last saw him alive on **Dec 12**, 19**45**  
and that death occurred on the date and hour stated above.

8. AGE: Years **78** Months **8** Days **16**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Pulmonary Tuberculosis** Duration **3 yrs**

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

10. Usual occupation **FARMER**

11. Industry or business \_\_\_\_\_

12. Name **Sharon M. Kehl**

13. Birthplace **Ky**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Ockree**

15. Birthplace **Ky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ella Mikel**

(b) Address **Huntsville Mo**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **12-15-1945**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Huntsville Mo**

18. (a) Signature of funeral director **E. C. Stapp**

(b) Address **Clarice**

19. (a) **Jan 2-1946** (Date received local registrar)

(b) **Mrs D. A. Bahrhart** (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **none**

Of autopsy **none**

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 **P. D. Dreyer** (M. D. or other) **MD**

Address **Huntsville Mo** Date signed **12/15/45**

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

100811

RECEIVED

District Health Officer No. 10

District File Number 1-46-225

Date Filed JAN 26 1946

**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..... *Louis E. Hopper* .....

Licensed Embalmer No. 4261

P. O. Address..... *Clarence, Mo* .....

**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.