S. No. 2
M—2-43
. 5-17-39
X35697

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. 31442

Registration District No. 3917 FILED OCT 7 1946 Primary Registration District No. 6076 Registrar's No. 2022

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (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 70 days (Specify whether

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County —

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 3628 Evans (If rural, give location) 9

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Joseph L. Mitchell

3. (b) If veteran, name war —

3. (c) Social Security No. 7

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Margaret Mitchell

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Aug (Month) 19 (Day) 1891 (Year)

8. AGE: Years 55 Months 91 Days 8 If less than one day hr. min.

9. Birthplace St. Louis, (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Sheet metal worker

11. Industry or business —

FATHER
12. Name William Mitchell 4
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Julia Horan 4
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Hospital Record

(b) Address Koch Hospital

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

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir

(b) Address 2849 No. Euclid Ave

19. (a) 10-1-46 (Date received local registrar) (b) Ruth I. Allen M.D. (Registrar's signature) No. Sh

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27 year 1946 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 19, 1946 to Sept 27, 1946; that I last saw him alive on Sept 27, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death (1) Chronic Pulmonary Tuberculosis	6 mos.
(2) Tuberculous enteritis	4 mos.
Due to —	
Due to —	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy Pulmonary and enteric tuberculosis

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? — (Specify type of place)

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

23. Signature Charles Sherburg (M. D. or other) M.D.

Address Koch Hospital, Koch, Mo Date signed 9/28/46

(Licensed Embalmer's Statement on Reverse Side)

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. 3553

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.