

FILED MAR 28 1948

Registration District No. \_\_\_\_\_

Primary Registration District No. **2000**

39  
2  
4  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Greene

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

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

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community 1 day

**3. (a) PRINT FULL NAME** Frances Augustia Mitchell

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Female

5. Color or race White

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

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

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

7. Birth date of deceased December-28-1892  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>54</u>	<u>2</u>	<u>10</u>	<u>x</u> hr. <u>x</u> min.

9. Birthplace Ozark County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Samuel Plaster

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

14. Maiden name Sarah Welch

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

16. (a) Informant Orville Mitchell (son)

(b) Address Springfield, Mo.

17. (a) Mt. Zion (b) Date thereof 3-10-47  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried Mt. Zion

18. (a) Signature of funeral director Ge. J. J. J.

(b) Address Marshfield, Mo.

19. (a) 3-12-47 (b) W. J. Handley MD  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Wright

(c) City or town Rural - Hartsville  
(If outside city or town limits, write "RURAL")

(d) Street No. Boone 1 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country x

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 8  
year 1947 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 7 1947 to Mar 8 1947  
that I last saw h. or alive on 3/7 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Diabetic Coma with suppression of urine

Due to Diabetes Mel.

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

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 6

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 W. J. Handley MD (M. D. or other) \_\_\_\_\_  
Address Springfield Mo Date signed 3/14/47

Duration 1 1/2  
Physician W. J. Handley MD  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

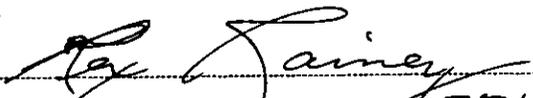
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**STATEMENT BY LICENSED EMBALMER**

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..... 3312

P. O. Address..... ~~3312~~ Marshfield, 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.**