

No. 2
2-45
17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

19166

FILED JUN 14 1947

1003

Registrar's No.

5642

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 DAYS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3242A MISSOURI AV 9
24 (If rural, give location)
(e) Citizen of foreign country? - No (Yes or No)
If yes, name country =

3. (a) PRINT FULL NAME GEORGE MITCHLER

3. (b) If veteran, name war = 3. (c) Social Security No. 494-03-2621

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FREDA REIM 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased April 5 1884
(Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation CHAUFFEUR

11. Industry or business TRUCKING

12. Name AL WILLE TRUCKING Co.

13. Birthplace SAMUEL MITCHLER IOWA
(City, town, or county) (State or foreign country)

14. Maiden name MARY LEOTA SCOTT

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

16. (a) Informant Jordan Mitchell

(b) Address 3242 Missouri Av

17. (a) BURIAL (b) Date thereof JUNE 10 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. TRINITY LUTHERAN

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

(b) Address 1936 St. Louis Av

19. (a) JUN 9 1947 (b) J.F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7 year 47 hour 10 minute 25 P.M.

21. I hereby certify that I attended the deceased from 6 1947 to 6-7 1947 that I last saw him alive on 6-7 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure
Due to Carcinoma of tongue

Other conditions: H7
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy: Carcinoma of tongue & metastasis to lymph nodes & spleen

22. If death was due to external causes, 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 St. Louis Hospital (Specify type of place of injury)

23. Signature S.W. Gollub (M. D. or other) City Hospital
Address City Hospital Date signed 6/7/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S.W. Gollub

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

MOTHER FATHER

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 *Walter Paulson*

Licensed Embalmer No. *4114*

P. O. Address *1936 St. Louis Ave*

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.