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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 8 1947
Registration District No. 62

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30675
Registrar's No. 28

Primary Registration District No. 5239

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

1. PLACE OF DEATH:
(a) County Cedar
(b) City or town Rural
(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 2 wks.
In this community 2 wks.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James M. Mitchell
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mary Bell Foster Mitchell
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased June 6 1865
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 22
If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business

MOTHER FATHER {
12. Name Mose Burlison Mitchell /
13. Birthplace Tenn. /
14. Maiden name Rachael Mitchell /
15. Birthplace unknown /
(City, town, or county) (State or foreign country)

16. (a) Informant W. C. Robinson
(b) Address Avocada Mo

17. (a) burial (b) Date thereof 9-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenfield Home Cemetery

18. (a) Signature of funeral director W. R. Allison
(b) Address Greenfield, Mo

19. (a) 9-29-47 (b) Geneva Barrigou
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cedar 20
(c) City or town Rural 20
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1947 hour 11 minute 45 a.m.

21. I hereby certify that I attended the deceased from 9-1 1947 to 9-29 1947
that I last saw him alive on 9-24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 200A
Of autopsy
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 J. H. Cowan (M. D. or other)
Address Greenfield Mo Date signed 9-29-47

RECEIVED
Division Health Officer No. 7
District File Number 9-47-1179
Date Filed 10-7-47

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 W. R. Allison.....

Licensed Embalmer No. 4404.....

P. O. Address Greenfield, 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.