

No. 2
-243
-1739
X38697

FILED DEC 19 1947 262

Primary Registration District No. 5887

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ozark

(b) City or town Idall
(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 six years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ozark

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

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME Minnie Mitchell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2
year 1947 hour 3 minute 17 M.

21. I hereby certify that I attended the deceased from Dec 1
1st 1947 to Dec 1st 1947;
that I last saw her alive on Dec 1
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race w

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

6. (b) Name of husband or wife Walter B. Mitchell

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

7. Birth date of deceased: Feb. 22 1893
(Month) (Day) (Year)

Immediate cause of death: Diabetic Coma Duration 12 hrs.

Due to Diabetes mellitus yes.

Due to _____

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

8. AGE: Years 54 Months 9 Days 10 If less than one day _____ hr. min.

9. Birthplace: Ozark Co. Ark
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name W. C. Watts

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

14. Maiden name Esther M Ramsey

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

16. (a) Informant Isaac Watts

(b) Address Wm Home Ark

17. (a) burial (b) Date thereof 12-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabland

18. (a) Signature of funeral director Werner Keller

(b) Address Wm Home Ark

19. (a) 12-24-47 (b) May Johnson
(Date received local registrar) (Registrar's signature)

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 2

23. Signature: W. C. Watts (M. D. or other) _____
Address: Cabland Ark Date signed 12-5-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE PERMANENT RECORD

ENCLOSURE

X

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 18

Registration District No. 262 Primary Registration District No. 5887

1. PLACE OF DEATH:
(a) County Ozark
(b) City or town Udell
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

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

3. (a) PRINT FULL NAME Minnie Mitchell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M. 2
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife N.B. Mitchell 6. (c) Age of husband or wife if alive 52
7. Birth date of deceased Jan 2 1895
(Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days _____ If less than one day, hr. _____ min. _____
9. Birthplace Ark
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Jan 2-48 (b) Carl Davis
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

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

42542