

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7616

FILED FEB 26 1948
357

Registration District No. _____

Primary Registration District No. 4526

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County VERNON
(b) City or town RURAL
(If outside city or town limits, write "RURAL" and name of township)
(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 13 yrs3. (a) PRINT FULL NAME Ed ROBERT MITTS3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife BELLA MITTS 6. (c) Age of husband or wife if alive 67 years7. Birth date of deceased May 4 1856
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
91 9 5 hr. _____ min.9. Birthplace SIAGMON ILL.
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business _____

12. Name SYRAS MITTS 913. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)14. Maiden name SARA GANE SATTON 915. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)16. (a) Informant HARRY MITTS(b) Address SHELDON MO.17. (a) BURIAL (b) Date thereof Feb 12-48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation DUNIGON GROVE18. (a) Signature of funeral director St. Bernard Bony(b) Address Sheldon Mo19. (a) Feb 21 1948 (b) Mrs. Ruth Faith
(Date received local registrar) (Registrar's signature) 250

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County VERNON MO(c) City or town RURAL
(If outside city or town limits, write "RURAL")(d) Street No. 3 MI. NORTH 4 MI. EAST SHELDON MO
(If rural, give location)(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
year 1948 hour 6 minute P.M.21. I hereby certify that I attended the deceased from 2-1 1948 to 2-9 1948that I last saw him alive on 2-5- 1948
and that death occurred on the date and hour stated above.Immediate cause of death pneumonia

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 U23. Signature StB Bannister (M. D. or other) _____Address Sheldon MO 2-10-48 Date signed

Duration

PHYSICIAN

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Underline the cause to which death is attributed statistically.

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

RECEIVED

District Health Officer No. 7

District File Number 1-48-107

Date Filed 2-25-48

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 E. Bernard Beems

Licensed Embalmer No. 4169

P. O. Address Sheldon 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.

Registration District No. 359 Primary Registration District No. 4526 Registrar's No. _____

1. PLACE OF DEATH: Vernon
(a) County Ma
(b) City or town Ma
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ed Robert Mitts
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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased May (Month) 20 (Day) _____ (Year)

8. AGE: Years 91 Months 9 Days _____ (Less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb year 1948 hour _____ minute _____ M.
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 _____

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? _____

23. Signature Sheldon (M. D. or other) _____
Address Sheldon Date signed _____
While at work _____ (Specify type of place) _____ (e) Means of injury _____

SUPPLEMENTARY

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

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

MOTHER FATHER

1948

S-7616

St. Louis, Mo.

2000

St. Louis, Mo.