

No. 2
02-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11938

State File No. _____
Registrar's No. 4

Registration District No. 80 Primary Registration District No. 5307

1. PLACE OF DEATH:
(a) County... Cole *Morgan Sup.*
(b) City or town... *Olean Rural*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) *1*
(d) Length of stay: In hospital or institution... (Specify whether)
In this community... *12yrs*
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State... *Rural Olean, Mo.* County... *Cole* *26*
(c) City or town... (If outside city or town limits, write "RURAL") *0*
(d) Street No... (If rural, give location) *0*
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country *0*

3. (a) PRINT FULL NAME *Charles N. Mitchell*
3. (b) If veteran, name war _____ 3. (c) Social Security No. *none*

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *March* day *31*, 1948
year _____ hour *8* minute *0* M.

4. Sex *Male* 5. Color or race *white* 6. (a) Single, widowed, married, divorced *Widowed*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased... *Feb. 5th 1948*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *March 27, 1948* to *March 31, 1948*, that I last saw him alive on *March 29, 1948* and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
85 *1* *26*
hr. min.

Immediate cause of death *Cerebral Apoplexy* Duration *5 days*
Due to _____
Due to _____

9. Birthplace *Weatherford Tex.*
(City, town, or county) (State or foreign country)
10. Usual occupation *Mill Wright*

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations *830*
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name *Charles Nally Mitchell*
13. Birthplace *Arkansas*
(City, town, or county) (State or foreign country)
14. Maiden name *Adeline Rattliff*
15. Birthplace *Louisiana*
(City, town, or county) (State or foreign country)
16. (a) Informant *Charles Mitchell*
(b) Address *Olean, Mo.*
17. (a) *Burial* (b) Date thereof *April 1, 48*
(Burial, cremation, or removal) (Month) (Day) (Year)
Enloe Cem
(c) Place: burial or cremation
18. (a) Signature of funeral director *Hugo H. Schubert*
(b) Address *Russellville, Mo.*
19. (a) *April* (b) *Hugh H. Nethermeyer*
(Date received local registrar) (Registrar's signature)

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) _____ (c) Means of injury _____
23. Signature *Walter L. Leslie* (M. D. or other) *0*
Address *Russellville, Mo.* Date signed *6-1-48*

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

RECEIVED
District Health Officer No. 9
District File Number
Date Filed APR 21 1948

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.....

Not Embalmed
..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Hugh H. Schubert

Licensee Embalmer No. *2870*

P. O. Address. *Russellville, 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.