

No. 2
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17-39
236671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 24 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13412

State File No.

Registration District No. 218

Primary Registration District No. 4330

Registrar's No. 25

PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Residence 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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town East Prairie MO 67
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 20
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME GERTRUDE MILLAR MITCHELL

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 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: July 29 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace East Prairie Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Insurance agent

11. Industry or business _____

12. Name John Abraham Millar

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

14. Maiden name Annie Kalfus

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

16. (a) Informant Mrs. Annie Roberts
(b) Address East Prairie, Mo.

17. (a) Burial (b) Date thereof March 28 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. & W. East Prairie, Mo.
18. (a) Signature of funeral director David Shelby
(b) Address East Prairie, Mo.

19. (a) 4-3-48 (b) Gertrude B. Harper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1948 hour 3 minute 22 A.M.

21. I hereby certify that I attended the deceased from 3-2 1948 to 3-26 1948
and that I last saw her alive on 3-25 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Disease of Heart Duration _____
Due to Embolicism of left leg.

Due to _____

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

Major findings: -
Of operations _____

Of autopsy 950

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 A. J. Martin (M. D. or other) _____
Address East Prairie Mo. Date signed 3/31/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Office No. 2,
District File Number 448-528
Date Filed 4-22-48

MAY 16 1952
JUN 6 1952

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 Travis Shelby
Licensed Embalmer No. 2726
P. O. Address East Prarie, 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. 218

Primary Registration District No. 4330

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(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

3. (a) PRINT FULL NAME Gertrude M. Mitchell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased July 29 (Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Insurance Agent

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 _____ (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 May Day 6 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 _____ Duration _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-13412