DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 27 1948

Registration District No. 217

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23616

Primary Registration District No. 5786

Registrar's No. 61

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: Charleston (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 2, Box 241
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ------ (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Mississippi

(c) City or town: Charleston (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No.: Route 2, Box 241
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ------

3. (a) PRINT FULL NAME: Robert Mitchell

3. (b) If veteran, name war: -------

3. (c) Social Security No. -----

4. Sex: Male

5. Color or race: Negro

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

6. (b) Name of husband or wife: Safronia Mitchell

6. (c) Age of husband or wife if alive: 41 years

7. Birth date of deceased: January 17, 1900
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
48	5	28	hr. min.

9. Birthplace: Shelby County, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: H enry Mitchell
13. Birthplace: Tenn.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Addie Rhodes
15. Birthplace: Shelby County, Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Safronia Mitchell
(b) Address: R.2, Box 241, Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 19, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove Cemetery

18. (a) Signature of funeral director: F. L. Sparks
(b) Address: Charleston, Mo.

19. (a) 7-21-48 (Date received local registrar) Mrs. John Bonderant (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1948 hour: 8:00 minute P. M.

21. I hereby certify that I attended the deceased from July 12, 1948, to July 15, 1948
that I last saw him alive on July 15, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Hemorrhage	1 hour
Due to: Pulmonary T.B.	1 yr.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
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: T. P. Fenlon (M. D. or other)
Address: Wyatt, Mo. Date signed: 7-15-48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK

RECEIVED
District Health Office N
District File Number 248
Date Filed 2-21-

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 Frank J. Sparks

Licensed Embalmer No. 3X05

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.