No. 300
10-48

FILED NOV 3 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33738

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001 Registrar's No. 4503

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
c. LENGTH OF STAY (in this place): 30 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 624 HARRISON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
d. STREET ADDRESS (If rural, give location): 624 HARRISON 3 | 20

3. NAME OF DECEASED (Type or Print)
a. (First): ELSIE
b. (Middle): AMELIA
c. (Last): MITCHELL

4. DATE OF DEATH (Month): 10 (Day): 16 (Year): 1951

5. SEX: FEMALE 3
6. COLOR OR RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 12-21-1898
9. AGE (In years last birthday): 52 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE KEEPER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): SAVANNAH, MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: DON'T KNOW
13b. MOTHER'S MAIDEN NAME: DON'T KNOW
14. NAME OF HUSBAND OR WIFE: GEORGE MITCHELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: GEO. MITCHELL **ADDRESS**: 633½ CAMPBELL

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*: Acute bronchopneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 49 hr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Thos. A. Jones M.D.
23b. ADDRESS: 1612 E 12 St.
23c. DATE SIGNED: 10/19/51

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 10-20-51
24c. NAME OF CEMETERY OR CREMATORY: WESTLAWN
24d. LOCATION (City, town, or county) (State): KANSAS CITY, KANSAS

DATE REC'D BY LOCAL REG.: 10-22-51
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: BRADY-BROWN **ADDRESS**: 1708 TRACY K.C., MO.

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 7 1962

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.