

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3123

State File No. \_\_\_\_\_

0152

FILED JAN 26 1952  
40275-51

318

1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Mo.  
b. COUNTY \_\_\_\_\_

b. CITY OR TOWN St. Louis  
c. LENGTH OF STAY (In this place) \_\_\_\_\_

a.c. CITY OR TOWN St. Louis  
d. STREET ADDRESS (If rural, give location) \_\_\_\_\_

d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital

4964 Miami St.

3. NAME OF DECEASED  
a. (First) ROBERT  
b. (Middle) MICHAEL  
c. (Last) MITCHELLETTE

4. DATE OF DEATH  
(Month) (Day) (Year)  
Jan. 5 1952

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH June 17, 1951

9. AGE (In years last birthday) 0  
IF UNDER 1 YEAR: Months 6 Days 18  
IF UNDER 18 HRS. Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13a. FATHER'S NAME Michael Mitchellette

13b. MOTHER'S MAIDEN NAME Mary Leto

14. NAME OF HUSBAND OR WIFE \_\_\_\_\_

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
Michael Mitchellette 4964 Miami St.

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Broncho pneumonia  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) afterburn's disease  
DUE TO (c) (Complete paralysis of intestinal tract)  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
1 week  
3 months

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) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR 744.1

22. I hereby certify that I attended the deceased from Birth, 19\_\_\_\_, to Jan 5, 1952, that I last saw the deceased alive on Jan 5, 1952, and that death occurred at 5:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joe P. ... M.D.

23b. ADDRESS 4952 Maryland

23c. DATE SIGNED 1/7/52

24a. BURIAL CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan. 8, 1952

24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JAN 7 1952  
REGISTRAR'S SIGNATURE Earl ...

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
Kriegshauser 4228 S. Kingshighway Bl.

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

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.....  
Student Embalmer

Signed *William R. White*

Licensed Embalmer No. *4291*

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.