

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36673

State File No. _____

NOV 13 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9952**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2721 A. DICKSON RESIDENCE		d. STREET ADDRESS (If rural, give location) 2721 A. DICKSON	

3. NAME OF DECEASED (Type or Print) a. (First) STEPHEN b. (Middle) c. (Last) MITCHELL		4. DATE OF DEATH (Month) (Day) (Year) 10-26-52	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Feb. 14, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY MYERS TOBACCO CO.	11. BIRTHPLACE (City and State or Foreign Country) OAKOLONA, MISSISSIPPI
13a. FATHER'S NAME PETER MITCHELL		13b. MOTHER'S MAIDEN NAME MATTIE DANCER	14. NAME OF HUSBAND OR WIFE ALBERTA MITCHELL

9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 8 Days 14	IF UNDER 1 YEAR Hours Min. 	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 493-24-6634	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. LOUISE HAMILTON 2324 EUCLID	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy 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
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334X

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 **11:55** p.m., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Rayless Coroner	(Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10 29 52.
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE OCT. 31, 1952	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.

DATE REC'D BY LOCAL REG. OCT 29 1952	REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE J. C. Smith	ADDRESS 1221 N. GRAND BLVD.
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(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Clarence Craigm

Licensed Embalmer No. 4755

P. O. Address 1221 N Grand

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.