

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

30254
7606

State File No.
Registrar's No.

No. 300
10.48

FILED AUG 31 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5163 ENRIGHT</u>		d. STREET ADDRESS (If rural, give location) <u>12 5163 ENRIGHT AVE.</u>	

3. NAME OF DECEASED (Type or Print) <u>MARY WALTHALL MITCHELL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7 31 53</u>		
5. SEX <u>F 3</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW 2</u>	8. DATE OF BIRTH <u>8-29-84</u>	9. AGE (In years last birthday) <u>68</u>	10. MONTHS <u>11</u> DAYS <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hopkinsville Ky 1</u>	
13a. FATHER'S NAME <u>CANKER DICKERSON</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET ROSCOE</u>		14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Georgia Wheeler</u> ADDRESS <u>5163 Enright</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MI</u> <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>410X</u>
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?

22. I hereby certify that I attended the deceased from 9-4, 1952, to 7-31, 1953, that I last saw the deceased alive on 7-71, 1953, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J.W. Wilkerson M.D. 0</u>	23b. ADDRESS <u>4141 Pope Blvd</u>	23c. DATE SIGNED <u>8-3-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>8-6-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>
24d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS MO</u>		

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 4 1953</u> <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A.F. Walton 2207 Stoddard</u>
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Licensed Embalmer's Statement on Reverse Side

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Hollis

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.