

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

45454

FILED JAN 19 1954

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State File No. 12090
 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 12090		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>0</u>				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, Mo.</u>			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital.</u>				e. STREET ADDRESS (If rural, give location) <u>19 447 No. Sarah.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>			b. (Middle) <u>Michael</u>		c. (Last) <u>Mitchell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 21, 1953.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 15, 1896.</u>		9. AGE (In years last birthday) <u>57.</u>	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) <u>Waiter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Argos Oresticon, Greece</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Michael Mitchell</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Jeanne Mitchell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If you, the registrar or dates of service) <u>Nil.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Jeanne Mitchell, 447 No. Sarah.</u>		ADDRESS _____			
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* (a) <u>Carcinoma, glandular</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of stomach</u> 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 <u>1 year</u> <u>6 mont</u>	
19a. DATE OF OPERATION <u>12. 18. 53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of stomach; carcinoma</u>						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) <u>St. Louis</u> <u>Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>151X</u>					
22. I hereby certify that I attended the deceased from <u>12. 10</u> , 19 <u>53</u> to <u>12. 21</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12. 17</u> , 19 <u>53</u> , and that death occurred at <u>12:00 p.m.</u> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Joseph H. Lynn M.D.</u>				23b. ADDRESS <u>1695 Brentwood</u>			23c. DATE SIGNED <u>12. 22. 53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-23-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>DEC 22 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>				

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.....
Signature of Student Embalmer

Signed.....
David J. Fanner

Licensed Embalmer No. *4788*
P. O. Address *St. Louis*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**