

32417

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED NOV 14 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 295

|                                                                                            |  |                                                                                                                                              |                                  |
|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>                                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u> |                                  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u> |  | c. LENGTH OF STAY (In this place) <u>11 days</u>                                                                                             | c. CITY OR TOWN <u>Lancaster</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #1</u>                           |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>                       |                                  |
|                                                                                            |  | e. STREET ADDRESS (If rural, give location) <u>09801</u>                                                                                     |                                  |

|                                     |                           |                       |                           |                                                          |
|-------------------------------------|---------------------------|-----------------------|---------------------------|----------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Spencer</u> | b. (Middle) <u>N.</u> | c. (Last) <u>Mitchell</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 8 1955</u> |
|-------------------------------------|---------------------------|-----------------------|---------------------------|----------------------------------------------------------|

|                    |                               |                                                                       |                                      |                                           |                        |                       |                       |                      |
|--------------------|-------------------------------|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------|------------------------|-----------------------|-----------------------|----------------------|
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u> | 8. DATE OF BIRTH <u>APR 29, 1882</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. Min. |
|--------------------|-------------------------------|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------|------------------------|-----------------------|-----------------------|----------------------|

|                                                                                                              |                                                    |                                                                   |                                             |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>unknown</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------|

|                                        |                                          |                                            |
|----------------------------------------|------------------------------------------|--------------------------------------------|
| 13a. FATHER'S NAME <u>Geo Mitchell</u> | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>unknown</u> |
|----------------------------------------|------------------------------------------|--------------------------------------------|

|                                                                                                                       |                                        |                                                                |                            |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>unknown</u> | 16. SOCIAL SECURITY NO. <u>unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital Record</u> | ADDRESS <u>Fulton, Mo.</u> |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------|----------------------------|

|                                                                                                                                                                                                                               |                                                                                                                                                                     |  |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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                                                                                                                                               |  | INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                               | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Arteriosclerosis</u>                                                                          |  |                                  |
|                                                                                                                                                                                                                               | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <u>4500</u> |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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 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) (Min.) | 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 Oct 27, 1955, to Nov. 8, 1955, that I last saw the deceased alive on Nov 8, 1955, and that death occurred at 10:30 Am, from the causes and on the date stated above.

|                                                                 |                                                   |                                 |
|-----------------------------------------------------------------|---------------------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>State Hospital 1, Fulton, Mo.</u> | 23c. DATE SIGNED <u>11/8/55</u> |
|-----------------------------------------------------------------|---------------------------------------------------|---------------------------------|

|                                              |                          |                                                     |                                                                   |
|----------------------------------------------|--------------------------|-----------------------------------------------------|-------------------------------------------------------------------|
| 24a. BY WHAT ORGANIZATION, REMOVAL (Specify) | 24b. DATE <u>11/8/55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Lancaster</u> | 24d. LOCATION (City, town, or county) (State) <u>Lancaster Mo</u> |
|----------------------------------------------|--------------------------|-----------------------------------------------------|-------------------------------------------------------------------|

|                                              |                                              |                                                     |                       |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------------|-----------------------|
| DATE REC'D BY LOCAL REG. <u>Nov. 12-1955</u> | REGISTRAR'S SIGNATURE <u>Martha Lawrence</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | ADDRESS <u>Fulton</u> |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------------|-----------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 15 1951

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 *J. J. Rossen*.....  
Licensed Embalmer No. *2585*

P. O. Address *Hullton*

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.