

FILED APR 2 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11169

1003

Registrar's No. 2948

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2948	
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 St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		209	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital				d. STREET ADDRESS (If rural, give location) 5131 Cabanne			
3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) Keller c. (Last) Mitchell			4. DATE OF DEATH (Month) (Day) (Year) March 21, 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 21, 1871		9. AGE (In years last birthday) 84	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Austin, Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Charles G. Kilian		13b. MOTHER'S MAIDEN NAME Mary Weber		14. NAME OF HUSBAND OR WIFE Lee Mitchell			
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 Oscar J. Schneider, 5131 Cabanne			
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) <u>Uremia - coma</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bilateral Renal Hypertension</u> DUE TO (c) <u>Left Renal Artery Thrombosis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis - generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 1/2</u> <u>Recurrent</u> <u>4 years</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>454 x</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)			
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 AND WHEN INJURY OCCURRED <u>John V. Lawrence</u> <u>3/21/56</u>			
22. I hereby certify that I attended the deceased from <u>3-21</u> , 19 <u>56</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-21</u> , 19 <u>56</u> , and that death occurred at <u>9:00 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John V. Lawrence</u>				23b. ADDRESS <u>3920 Washington Ave. St. Louis, Mo.</u>		23c. DATE SIGNED <u>3-21-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE <u>3-23-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
DATE REC'D BY LOCAL REG. <u>MAR 22 1956</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd</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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed W. Wilkinson

Licensed Embalmer No. 3575

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 this body is not embalmed, fact should be so stated above.