

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27001

FILED AUG 28 1956

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 117

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>PIKE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CLARKSVILLE 0820</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP.</u>			Length of stay in 1b <u>24 DAYS</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>ETTA</u> Middle <u>MUELLER</u> Last			4. DATE OF DEATH Month <u>AUG.</u> Day <u>21</u> Year <u>1956</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 12, 1896</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEAUTY SHOP</u>		11. BIRTHPLACE (City and state or country) <u>HAMBURG, ILL.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>GEORGE MITCHELL</u>		
14. MOTHER'S MAIDEN NAME <u>LAURA COX</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>488-30-045</u>			17. INFORMANT <u>HOSPITAL RECORDS</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of the stomach</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>151X</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 26, 1956</u> to <u>August 21, 1956</u> and last saw her/him alive on <u>August 21, 1956</u> Death occurred at <u>8:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) <u>D. Becher, M.D.</u>			22b. ADDRESS <u>Clarksville Mo</u>		22c. DATE SIGNED <u>8/21/56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>AUG. 22, 56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEM.</u>	
23d. LOCATION (City, town, or county) <u>ST. LOUIS, MISSOURI</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>BEIDERWIEDEN - ST. LOUIS, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 21, 1956</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

FUNERAL HOME (Licensed Embolmer's Statement on Reverse Side)

374-

107 8 1558

SEP 13 1958

AUG 28 1956

1881 9 7 1957

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 *Geo. M. Collier*

Licensed Embalmer No. *38*

P. O. Address *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.