

Health,
Welfare
Public
Service

300
1-56

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**

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1956

36600

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2376

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis,</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Anns</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Anns</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>11253 S. Shawn Lane</u>		Length of stay in 1b <u>16 Mos</u>	d. STREET ADDRESS (If outside, give location) <u>11253 St. Shawn Lane</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Bell</u> Last <u>Mitchell</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</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"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1872</u>	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </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>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Ballard Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give war or dates of service) No. <u> </u> Nil <u> </u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Nacy Mitchell, 11253 St. Shawn Lane,</u> Address <u>St. Anns, Mo.</u>		
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>Typhoid</u> DUE TO (b) <u>Sensitivity</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I((n)) <u>593x</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>					
20d. INJURY OCCURRED WHILE AT <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>8-1-55</u> to <u>10-7-56</u> and last saw her alive on <u>10-7-56</u> Death occurred at <u>3:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert A. Steen DC</u>			22b. ADDRESS <u>8999 St. Charles Rd.</u>		22c. DATE SIGNED <u>10-9-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-9-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ripley County, Mo.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe 4700 Washington,</u> ADDRESS <u> </u>			25. DATE RECD. BY LOCAL REG. <u>10-9-56</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Dornick MD</u>

(Licensed Embalmer's Statement on Reverse Side)

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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 *Stanley F. Dixon*

Licensed Embalmer No. *41*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.