

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

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

662

STATE FILE NUMBER

FILED JAN 21 1957

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cameron		c. CITY OR TOWN Gower	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cameron Community Hosp.		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Marvin Middle Cecil Last Mitchell		4. DATE OF DEATH Month Jan. Day 9, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Gower Mo.
13. FATHER'S NAME Alonzo Mitcehl		14. MOTHER'S MAIDEN NAME Lillie Herffey	
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 Address Lillie Mitcehl Gower Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) obesity, extreme			INTERVAL BETWEEN ONSET AND DEATH 3 days
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 Jan 7 1957 to Jan 9 1957 and last saw her alive on Jan 9 1957 . Death occurred at 8 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Howard Carter M.D.		22b. ADDRESS Hamilton Mo	
		22c. DATE SIGNED Jan 10 1957	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/57	
23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d. LOCATION (City, town, or county) (State) Gower Mo	
24. FUNERAL DIRECTOR John F. Guff		25. DATE RECD. BY LOCAL REG. 1-15-57	
ADDRESS St. Joseph, Mo		26. REGISTRAR'S SIGNATURE Francis D Crawford	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *John E. Rupp*
Licensed Embalmer No. *39*

P. O. Address *St. Joe*

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.