

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1957

10760

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2372**

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 casually 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				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS MO</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>01 2218 S. 4<sup>th</sup></i>			Length of stay in 1b <i>1</i>	STREET ADDRESS <i>2218 S. 4<sup>th</sup> ST.</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>WILLIAM MITCHELL</i>				4. DATE OF DEATH <i>MAR. 7 1957</i>		Month Day Year		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAR. 24 1897</i>		9. AGE (In years last birthday) <i>59</i> 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) <i>TRUCK DRIVER</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>KERN CO.</i>		11. BIRTHPLACE (City and state or country) <i>ST. LOUIS MO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>MITCHELL</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES WAR I</i>			16. SOCIAL SECURITY NO. <i>497-03-7758</i>		17. INFORMANT <i>CAROLINE MITCHELL</i>			Address <i>2218 S. 4<sup>th</sup> ST</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>cirrhosis of the Liver</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>581.0</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>4 years</i>	
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 a. m. p. m. Month, Day, Year								
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 <i>Feb. 1-57</i> to <i>March 7-57</i> and last saw her/him alive on <i>Mar 7-57</i> Death occurred at <i>10:30</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Type or title) <i>D. John Blaney M.D.</i>				22b. ADDRESS <i>2105 So. Broadway</i>		22c. DATE SIGNED <i>3/8/57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>MAR. 11, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>JEFFERSON BARRACKS</i>			
24. FUNERAL DIRECTOR <i>Thomas Kutas 2906 Gravois</i>			25. DATE RECD. BY LOCAL REG. <i>MAR 9 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>			

(Licensed Embalmer's Statement on Reverse Side)

1108 D. 11-2 P.M.

R 13948

Fri 7-8 P.M.

Sat 11-2 P.M.

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 Shun e Will

Licensed Embalmer No. 434

P. O. Address 2906 Dr

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.