

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33886

STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8504

300
-57

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, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1910 512 Culver Way		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ernest Mitchell			4. DATE OF DEATH Month - Day - Year Sept. 8, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1910	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cave In Rock, Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Mose Mitchell		13b. MOTHER'S MAIDEN NAME Lou McDowell		14. NAME OF HUSBAND OR WIFE Unavailable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) Yes No		16. SOCIAL SECURITY NO. 498-09-1723	17. INFORMANT Address John Mitchell, 5321 Delmar		
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>Internal Hemorrhage</i> DUE TO (b) <i>Laceration of the Right Leg</i> DUE TO (c) <i>Multiple Fractures of the Ribs.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <i>supper when slipping</i> <i>stepped from window</i> <i>fell into gutter to impact below at</i> <i>Homer G. Phillips Hospital, crack</i> <i>time unknown, September 8th</i> <i>E978X</i>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter signature of injury in PART I or PART II if item 18.) <i>as above</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour Month, Day, Year ? 9 8 57 1957		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.) <i>Shop</i>	
20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 803 A _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Patricia Taylor Corwin</i> (Deceased or title)			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9.10.57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>9-11-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Albert H. Hoppe 4700 Washington,</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 10 57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>mjs</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *G. W. Wilkins*

Licensed Embalmer No. *3575*

P. O. Address *M. L. Smith*

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.