

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3327
STATE FILE NUMBER
1405

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1405

300
1-57

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		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 6 weeks	
d. STREET ADDRESS 6160 Waterman Blvd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IRVIN REA MITCHELL			4. DATE OF DEATH Month Day Year Feb. 5 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1901
9. AGE (In years last birthday) 56		10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer & lawyer		10b. KIND OF BUSINESS OR INDUSTRY A.S. Aloe & Co.	11. BIRTHPLACE (City and state or country) North Andover, Mass.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Thomas Mitchell	
13b. MOTHER'S MAIDEN NAME Sarah Wooband		14. NAME OF HUSBAND OR WIFE Freda Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO.	
17. INFORMANT Freda Mitchell, 6160 Waterman Blvd.		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>Retno peritoneal sarcoma with metastases</u> 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) 158x			INTERVAL BETWEEN ONSET AND DEATH About 18 mo
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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 11/13/57 to Feb 5-58 and last saw her alive on Feb 4-58 Death occurred at 1 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert J. Warner M.D.		22b. ADDRESS 818 Olive St St Louis MO	
22c. DATE SIGNED Feb 6-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE 2-7-58	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR C. R. Lupton & Sons-7233 Delmar		25. DATE RECD. BY LOCAL REG. FEB 6 58	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. M.F.B.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, Coroner, etc. must use only standard nomenclature in item 16. No symptoms will be related. All diseases in Part I must be causally related.

THURSDAY 11:00 TO 4:00

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 *Clarence H. Mur*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo*

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.