

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033471

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Macon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Macon</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>Blackborn St. vrs.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>Blackborne St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Francis</u> Last <u>Mitchell</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1885</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>—</u>	11. BIRTHPLACE (City and state or country) <u>Collae, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Tom Lowery</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Lowery</u>	14. NAME OF HUSBAND OR WIFE <u>Orough Mitchell Sr.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no.</u>	17. INFORMANT <u>Lucielle Grant Macon, Mo.</u> Address _____
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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>Carcinoma ascending colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>1530</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetics Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <u>1530</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1530</u>	20f. CITY, TOWN, OR LOCATION <u>1530</u>	COUNTY _____	STATE _____
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21. I attended the deceased from <u>21 Aug 58</u> to <u>21 Aug 58</u> and last saw her alive on <u>21 Aug 58</u> Death occurred at <u>215</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Donald E Eggleston MD</u>	22b. ADDRESS <u>Macon, Missouri</u>	22c. DATE SIGNED <u>29 Aug 58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Collae, Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Collae Mo.</u>
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24. FUNERAL DIRECTOR <u>Lester Hutton</u>	ADDRESS <u>Macon Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/31/58</u>	26. REGISTRAR'S SIGNATURE <u>Cuth McNeely</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1958

S. 300
y. 1-57
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FILED SEP 17 1958

County File No.
Date Filed 9-15-58

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 *Charles L. Shuttles*

Licensed Embalmer No. *4577*

P. O. Address *Macon, 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.