

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035556

STATE FILE NUMBER

1106

FILED OCT 20 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

S. 300
1-57
4

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Sunnyslope Nursing</i>		Length of stay in lb <i>3 weeks</i>	d. STREET ADDRESS <i>208 South 10th</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>Clyde</i> Last <i>Mitchell</i>			4. DATE OF DEATH Month <i>October</i> Day <i>14</i> Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 18, 1889</i>	9. AGE (In years last birthday) <i>69</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Craig, Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Joseph W. Mitchell</i>		13b. MOTHER'S MAIDEN NAME <i>Nancy Dawson</i>		14. NAME OF HUSBAND OR WIFE <i>Dorothy A. Mitchell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Everett Mitchell</i> Address <i>Easton, Missouri</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>Cerebral hemorrhage</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>arterio-sclerotic heart disease</i>					<i>not sure</i>
DUE TO (c) <i>4200</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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>Oct 1-58</i> to <i>Oct 14-58</i> and last saw her alive on <i>Oct 13-58</i> Death occurred at <i>12:30 a.m. Oct 14-58</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Collis Rounly M.D.</i>			22b. ADDRESS <i>Wertzpa Truck Bldg</i>		22c. DATE SIGNED <i>OCT 15-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>October 16, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mount Hope</i>		23d. LOCATION (City, town, or county) (State) <i>Mound City Missouri</i>
24. FUNERAL DIRECTOR'S ADDRESS <i>James Crawford Mound City, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>Oct. 15, 1958</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>

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.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Collis Rounly

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 *James H. Crawford*

Licensed Embalmer No. *4796*

P. O. Address *Mound City,*

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.