Health, Welfare Public Service

300
1-57
33
7I

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007462
STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1085

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Venice — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Mary's Inf. — Length of stay in 1b 5 days	d. STREET ADDRESS (If outside, give location) 113 Weaver — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First ANNIE Middle Last MITCHELL			4. DATE OF DEATH Month Day Year Jan 27, 1959
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH Dec 28,1891
9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Jefferson City, Mo. 6	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Robert Jenkins	13b. MOTHER'S MAIDEN NAME Mary Ann Stewart	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Eunice Griggs-916 Address Madison,Madison,Ill	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: uremia

IMMEDIATE CAUSE (a) [illegible]

chronic nephritis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chr. Nephritis

chr. myocarditis

DUE TO (c) Chr. Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 1/24/59, to 1/27/59 and last saw her/him alive on 1/27

Death occurred at 1/27/59 34 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edgar Woodson [illegible]	22b. ADDRESS E. St.Louis, Ill. [illegible]	22c. DATE SIGNED 1/27/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/30/59	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) East St. Louis, Ill.		
24. FUNERAL DIRECTOR ADDRESS Marshall Fun Home-E.St.Louis,Ill	25. DATE RECD. BY LOCAL REG. JAN 30 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MAY 10 1961

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 Thomas M. Haber

Licensed Embalmer No. 479

P. O. Address East St. Louis

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.