

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010425

STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rolla		c. CITY OR TOWN ST. James	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MEARLAND Home		d. STREET ADDRESS (If outside, give location) 8 mo.	

3. NAME OF DECEASED (Type or print) First Middle Last EARL ORETH MITCHEM			4. DATE OF DEATH Month Day Year 3-27-59		
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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 7-2-1902	9. AGE (In years, Months, Days) 56 8 23	IF UNDER 1 YEAR Hours Min.	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) minister + teacher	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) Maries Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME S.E. MITCHEM	13b. MOTHER'S MAIDEN NAME LAURA TRAVIS	14. NAME OF HUSBAND OR WIFE ERA MITCHEM
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO. ✓	17. INFORMANT Address ERA MITCHEM - ST. JAMES, MO
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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) Cerebral hemorrhage arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	331X

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"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 9/7/58 to 3/27/59 and last saw him alive on 3/27/59 Death occurred at 4:25 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deceased or title) Wm R. L. Stoll	22b. ADDRESS Rolla Mo	22c. DATE SIGNED 3/27/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-29-59	23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery	23d. LOCATION (City, town, or county) (State) Belle, MO.
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24. FUNERAL DIRECTOR Oral E. Lecklider	ADDRESS St. James, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 30, 1959	26. REGISTRAR'S SIGNATURE Nadrie L. Stoll
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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380

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 me, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Oral E. Licklider

Licensed Embalmer No. 3-546
P. O. Address St. James, 7

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.