

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016648

STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 1071

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico Mo</b>		c. CITY OR TOWN <b>Truesdale Mo</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain Co</b>		d. STREET ADDRESS (If outside, give location) <b>none</b>	
Length of stay in lb <b>6 weeks</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah C. Mitchell</b>			4. DATE OF DEATH Month Day Year <b>5-18-1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-1870</b>
9. AGE (In years last birthday) <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Callaway Co Mo</b>
13a. FATHER'S NAME <b>James Gee</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Barnes</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	14. NAME OF HUSBAND OR WIFE <b>Sanford Mitchell "Decd"</b>
17. INFORMANT <b>Mrs Fernil Mitchell New Florence Mo</b>		Address <b>4200</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with heart block + fibrillation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
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)			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 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
21. I attended the deceased from <b>11-13-58</b> to <b>May 8, 1959</b> and last saw her alive on <b>May 17, 1959</b> Death occurred at <b>11:15 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, degree or title) <b>M. D.</b>		22b. ADDRESS <b>Mexico, Mo</b>	22c. DATE SIGNED <b>May 21, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>High Point Cem</b>	23d. LOCATION (City, town, or county) (State) <b>3 mi west Montgomery Mo</b>
24. FUNERAL DIRECTOR <b>Blanche Neely</b>		ADDRESS <b>MONTGOMERY CITY MO</b>	25. DATE RECD. BY LOCAL REG. <b>May 21-1959</b>
		26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>	

Part I must be typewritten. Part II must be typewritten or ribbon type. Part III must be typewritten or ribbon type. Part IV must be typewritten or ribbon type. Part V must be typewritten or ribbon type. Part VI must be typewritten or ribbon type. Part VII must be typewritten or ribbon type. Part VIII must be typewritten or ribbon type. Part IX must be typewritten or ribbon type. Part X must be typewritten or ribbon type. Part XI must be typewritten or ribbon type. Part XII must be typewritten or ribbon type. Part XIII must be typewritten or ribbon type. Part XIV must be typewritten or ribbon type. Part XV must be typewritten or ribbon type. Part XVI must be typewritten or ribbon type. Part XVII must be typewritten or ribbon type. Part XVIII must be typewritten or ribbon type. Part XIX must be typewritten or ribbon type. Part XX must be typewritten or ribbon type. Part XXI must be typewritten or ribbon type. Part XXII must be typewritten or ribbon type. Part XXIII must be typewritten or ribbon type. Part XXIV must be typewritten or ribbon type. Part XXV must be typewritten or ribbon type. Part XXVI must be typewritten or ribbon type. Part XXVII must be typewritten or ribbon type. Part XXVIII must be typewritten or ribbon type. Part XXIX must be typewritten or ribbon type. Part XXX must be typewritten or ribbon type.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *C. W. Hopkins* .....

C. W. Hopkins

Licensed Embalmer No. I487 .....  
Montgomery City Mo  
P. O. Address .....

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.