

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017867

FILED MAY 29 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2348 Registrar's No. 2348

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1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> 337 <sup>th</sup> 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>TRINITY LUTHERAN</u>		Length of stay in lb <u>40 years</u>	d. STREET ADDRESS (If outside, give location) <u>3722 E 37<sup>th</sup> TERR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1959</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</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>JULY 7 1903</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days 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) <u>CAR SALESMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	11. BIRTHPLACE (City and state or country) <u>Holt, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Edwin Mitchell</u>	13b. MOTHER'S MAIDEN NAME <u>Sadie Babcock</u>	14. NAME OF HUSBAND OR WIFE <u>EThel Mitchell</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>495-03-2089</u>	17. INFORMANT <u>VERA A CAIN</u>	Address <u>3624 N. Monroe</u>
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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>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Bactites with bleeding - proven surgically.</u>	<u>48 hours</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema - Coronary artery disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>Sept, 1955</u> to <u>May 4, 1959</u> and last saw her/him alive on <u>May 3, 1959</u> Death occurred at <u>5:00 AM May 3, 1959</u> 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>B. Comer Bates, M.D.</u>	22b. ADDRESS <u>2730 South Mall Antioch Center, Kansas City 16 Mo.</u>	22c. DATE SIGNED <u>5/4/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old GERMAN</u>	23d. LOCATION (City, town, or county) (State) <u>PIATTE Co. MO</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer Sons N.K.C.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

G. Comer Bates

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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 *[Handwritten Signature]* ..... Licensed Embalmer No. *4848* ..... P. O. Address *[Handwritten 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.