

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026965

STATE FILE NUMBER
REGISTRATION NO. 6435

FILED VS JUL 24 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN East St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If outside, give location) 415 South 40th Street	
Length of stay in 1b 1 Week		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE LAST PETE MITCHELL			4. DATE OF DEATH Month Day Year July 5, 1959			
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Aluminum Ore Co.	11. BIRTHPLACE (City and state or country) Camptie, Louisiana	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Peter Mitchell	13b. MOTHER'S MAIDEN NAME Florence Randolph	14. NAME OF HUSBAND OR WIFE Vera Green Mitchell
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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) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Vera Mitchell, 415 So. 40th Street,	Address E. St. Louis, Ill.
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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>CARDIAC DECOMPENSATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	<u>1 YEAR</u>
	DUE TO (c) <u>420.0</u>	
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 JUNE 25 to JULY 5 and last saw ^{her}him alive on JULY 5
Death occurred at 10 P m on the date stated above; and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>Frank Woodson, M.D.</u> (Degree or title)	22b. ADDRESS <u>908 N. 2ND ST.</u>	22c. DATE SIGNED <u>7/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/12/59	23c. NAME OF CEMETERY OR CREMATORY Sunset Garden of Memory	23d. LOCATION (City, town, or county) (State) Stookey Township, Illinois
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24. FUNERAL DIRECTOR <u>Marion's Office</u> ADDRESS 2114 Missouri Ave. E. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. JUL 8 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> -mbs
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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1-57

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 *Frank Prokoff*

Licensed Embalmer No. *4356*

P. O. Address *St. Louis, Mo.*

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.