

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

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Registration District No. 128 Primary Registration District No. 1000 Registrar's No. 1419 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>BRENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>NIANGUA MO</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5 MI EAST</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILMA FERN MITCHELL</u>			4. DATE OF DEATH Month Day Year <u>DEC 28 1959</u>			
5. SEX <u>FEMALE</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>8-17-1916</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>WILLIAM MAH</u>		13b. MOTHER'S MAIDEN NAME <u>MARY KENNEDY</u>		13c. NAME OF HUSBAND OR WIFE <u>JAMES MITCHELL</u>		
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. _____	17. INFORMANT <u>JAMES MITCHELL NIANGUA MO</u> Address _____			
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>3<sup>RD</sup> DEGREE BURNS 98% OF BODY</u>					INTERVAL BETWEEN ONSET AND DEATH <u>57 HRS.</u>	
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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>HOUSE FIRE</u>				
20c. TIME OF INJURY Hour a.m. <u>7:30</u> Month, Day, Year <u>DEC. 26 '59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. CITY, TOWN OR LOCATION <u>5 miles East NIANGUA</u>	COUNTY <u>WEBSTER</u>	STATE <u>MO.</u>	
21. I attended the deceased from <u>26 DEC. '59</u> to <u>28 DEC. '59</u> and last saw her alive on <u>28 DEC. '59</u> Death occurred at <u>11:17 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>29 Dec. 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-28-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WORLEY</u>	23d. LOCATION (City, town, or county) (State) <u>OKLAHOMA CO OKLA</u>			
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u>		ADDRESS <u>_____</u>	25. DATE RECD. BY LOCAL REG. <u>12-31-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 George Stoffe

Licensed Embalmer No. 3161  
P. O. Address Mr. George Stoffe

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.