

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-007032

STATE FILE NUMBER

FILED VS MAR 7 1960

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Lafayette 6542</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lexington 6542</u>		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>216 South 9th 90</u>			Length of stay in lb <u>Life</u>		d. STREET ADDRESS (If outside, give location) <u>216 South 9th</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>CLEVELAND</u> Last <u>MITCHELL</u>				4. DATE OF DEATH Month <u>February</u> Day <u>29</u> Year <u>1960</u>				
5. SEX <u>Male 0</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>8-29-1885</u>	9. AGE (In years, birth day) <u>74</u>	UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>David L. Mitchell</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Belle Meredith</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Lucy 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. <u>494-12-4712</u>		17. INFORMANT Address <u>Mrs. Lucy Mitchell, Lexington, Missouri</u>				
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>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>1st coronary seven years previous</u>				DUE TO (c) <u>4201</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 a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <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 <u>2/29/60</u> to <u>2/29/60</u> and last saw her alive on <u>2/29/60</u> Death occurred at <u>2:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Ben H. Brasher M.D.</u>			22b. ADDRESS <u>Lexington Mo.</u>			22c. DATE SIGNED <u>3/2/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)		
<u>Burial</u>	<u>3-3-1960</u>	<u>Machpelah</u>		<u>Lexington</u>		<u>Missouri</u>		
24. FUNERAL DIRECTOR <u>Forrest Tempel, Lexington MO</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-5-60</u>		26. REGISTRAR'S SIGNATURE <u>Wm. E. Eubank</u>		

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.

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 *Farrest J. Gumpel* .....

Licensed Embalmer No. *3995* .....

P. O. Address *Livingston* .....

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.