

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024774

FILED VS JUN 27 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5837** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN Saint Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5092 Enright Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JAMES C. MITCHELL			4. DATE OF DEATH Month Day Year JUNE 5 1960			
5. SEX Male	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 5/18/03	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (City and state or country) Tubalo, Miss.		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME George Mitchell		13b. MOTHER'S MAIDEN NAME Willie		14. NAME OF HUSBAND OR WIFE Florence Mitchell	
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. 494-10-4555		17. INFORMANT Address Florence Mitchell 5092 Enright	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) DISSECTING AORTIC ANEURYSM		FEW MINUTES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) AORTIC ANEURYSM	3 YEARS
	DUE TO (c) 451X	
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 type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 **JAN. 25, 1958** to **JUNE 5, 1960** and last saw ^{her}/_{him} alive on **JUNE 5, 1960**
Death occurred at **10:34 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) <i>C. Vermillion, M.D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/6/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/11/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. JUN 7 1960	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2009 10 10 11:00 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Geoffrey Swann*

Licensed Embalmer No. ~~1875~~ 45

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.