

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG. 24 1960

318

Primary Registration District No. 1003

Registrar's No.

8027-60-032622
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b 1 1/2 Days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1944 a Cherokee St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Delbert Last Mitchell						4. DATE OF DEATH Month August Day 13 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-11-1960		9. AGE (last birthday) IF UNDER 1 YEAR Months 1 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Edward D. Mitchell				13b. MOTHER'S MAIDEN NAME Lola Marler				14. NAME OF HUSBAND OR WIFE -----	
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. None		17. INFORMANT Address Edward D. Mitchell 1944 a Cherokee St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal septal defect								INTERVAL BETWEEN ONSET AND DEATH congest	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b)		DUE TO (c) 754.3			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hyper membrane disease						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 a.m. p.m. Month, Day, Year		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 8-13-60 to 8-14-60 and last saw her/him alive on 8-13-60 Death occurred at 2 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>E. Smith</i>					22b. ADDRESS 3478 S. Grand			22c. DATE SIGNED 8/15/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Good Hope Cemetery		23d. LOCATION (City, town, or county) (State) Harrisburg, Illinois			
24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 7814 S. Broadway					25. DATE RECD. BY LOCAL REG. AUG 15 1960		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John Shenn
Licensed Embalmer No. 4194
P. O. Address St. Lou

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.