

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1960

-60-035862

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 374

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre	Length of stay in 1b	c. CITY OR TOWN Leadington, Mo	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First John Middle Hugh Last Mitchell	4. DATE OF DEATH Month Sept Day 20 Year 1960
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5. SEX <input checked="" type="checkbox"/> Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1885 75	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Bonne Terre, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John L. Mitchell	13b. MOTHER'S MAIDEN NAME Carrie E. Highley	14. NAME OF HUSBAND OR WIFE None
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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. 499-20-8868	17. INFORMANT Miss Marie Mitchell Esther, Mo.	Address
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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) Generalized Carcinomatous DUE TO (b) Ca of Gall bladder DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio Sclerotic Heart 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
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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.)
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20c. TIME OF INJURY Hour 6:30 a.m. p.m.	Month, Day, Year Aug 1, 1960
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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 Bonne Terre, Mo	COUNTY St. Francois	STATE Mo
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21. I attended the deceased from **Aug 1, 1960** to **Sept 20 '60** and last saw ^{her} him alive on **Sept 19 '60**
Death occurred at **6 30 AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE P H Appleberry MD	(Degree or title)	22b. ADDRESS Leadington, Mo.	22c. DATE SIGNED 9-22-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-22-1960	23c. NAME OF CEMETERY OR CREMATORY St. Francois Memorial Park	23d. LOCATION (City, town, or county) Bonne Terre, Mo	(State)
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24. FUNERAL DIRECTOR R. Caldwell & Sons Flat River, Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. Sept. 23, 1960	26. REGISTRAR'S SIGNATURE Esther Rudloff
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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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River

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.