

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044827

LED VS NOV 28 1960 333

Primary Registration District No. 3074 Registrar's No. 273

STATE FILE NUMBER

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Scott</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>SCOTT</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Sikeston</b>                           |  | Length of stay in 1b<br><b>20 YRS.</b>  | c. CITY OR TOWN <b>SIKESTON</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>113 THOMPSON</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |  |
|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLIE</b> Middle <b>MITCHELL</b> Last <b>MITCHELL</b> | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>11</b> Year <b>1960</b> |
|---|--|

|                    |                               |   |                                    |                                  |   |  |
|--------------------|-------------------------------|---|------------------------------------|----------------------------------|---|--|
| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>NEGRO</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-25-1897</b> | 9. AGE (last birthday) <b>63</b> | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>16</b> Hours <b></b> Min. <b></b> | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b> |
|--------------------|-------------------------------|---|------------------------------------|----------------------------------|---|--|

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OIL MILL WORK</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>MISS.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.A.A.</b> |
|---|-----------------------------------|--|--|

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><b>ADAM MITCHELL</b> | 13b. MOTHER'S MAIDEN NAME<br><b>VICTORIA BUCKLIN</b> | 14. NAME OF HUSBAND OR WIFE<br><b>-</b> |
|--|--|---|

|   |                         |  |         |
|---|-------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>BARBARA GROSS, SIKESTON, MO.</b> | Address |
|---|-------------------------|--|---------|

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GI Hemorrhage from Peptic Ulcer.</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| DUE TO (b) <b>Gangrene Rt leg &amp; foot</b>  |  | <b>3 wks</b>                                      |
| DUE TO (c) <b>Diabetes Mellitus</b>   |  | <b>unknown</b>                                    |

|   |  |  |
|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>(11) Mid thigh Amputation Rt. (2) Coronary Insufficiency</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|--|

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b></b> a.m. <b></b> p.m. <b></b> | Month, Day, Year <b></b> |
|---|--------------------------|

|  |  |  |                              |
|--|--|--|------------------------------|
| 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<br><b>Sikeston, Mo.</b> | COUNTY <b></b> STATE <b></b> |
|--|--|--|------------------------------|

|  |  |
|--|--|
| 21. I attended the deceased from <b>11/4/60</b> to <b>11/11/60</b> and last saw <sup>her</sup> him alive on <b>11/10/60</b><br>Death occurred at <b>5:05 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |
|--|--|

|   |                                      |                                     |
|---|--------------------------------------|-------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>Max C. Hunt MD</b> | 22b. ADDRESS<br><b>Sikeston, Mo.</b> | 22c. DATE SIGNED<br><b>11-11-60</b> |
|---|--------------------------------------|-------------------------------------|

|  |                                |   |   |
|--|--------------------------------|---|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE<br><b>11-15-1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET</b> | 23d. LOCATION (City, town, or county) (State)<br><b>SIKESTON, MO.</b> |
|--|--------------------------------|---|---|

|  |                           |                              |  |
|--|---------------------------|------------------------------|--|
| 24. FUNERAL DIRECTOR<br><b>ALVIN DOTSON, SIKESTON, MO.</b> | ADDRESS<br><b>11-3-60</b> | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Ella Hunter</b> |
|--|---------------------------|------------------------------|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tris S. Mansboro

Licensed Embalmer No. 4660

P. O. Address Ashtabula

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