

61-008404

STATE FILE NUMBER

THE DIVISION OF HEALTH OF MISSOURI

FILED VS MAR 13 1961 STANDARD CERTIFICATE OF DEATH

Dept. Health, Educ., & Welfare U. S. Public Health Service

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 235

V. S. 300 Rev. 1-57

0397

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>438 S. National Ave.</b>		Length of stay in lb <b>59 years</b>	d. STREET ADDRESS (If outside, give location) <b>438 S. National Ave.</b>
3. NAME OF DECEASED (Type or print) First <b>LILLY</b> Middle <b>MAY</b> Last <b>MITCHELL</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/1870</b>
9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>months</b>	IF UNDER 24 HRS. Hours <b>about 40 yrs.</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Pract. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	11. BIRTHPLACE (City and state or country) <b>Alhambra, Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James M. Mitchell</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Isabelle Kinder</b>		14. NAME OF HUSBAND OR WIFE <b>----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Bessie A. Mitchell, Springfield, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>medullary failure</b> DUE TO (b) <b>ischemotic encephalomalacia</b> DUE TO (c) <b>arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>332X</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>7 months - about 40 yrs.</b>		19. WAS AUTOPSY PERFORMED? <b>2 YES</b> <input type="checkbox"/> <b>NO</b> <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 <b>10:00 A.M.</b> 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 <b>April 1956</b> to <b>3-4-61</b> and last saw her alive on <b>3-1-61</b> Death occurred at <b>10:00 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>E. L. Williams, D.O.</b>	
22b. ADDRESS <b>334 Sanders Olds Springfield, Mo.</b>		22c. DATE SIGNED <b>3-6-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/7/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>
23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Missouri</b>		25. DATE RECD. BY LOCAL REG <b>3-7-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>

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

*Keith Collins*

Licensed Embalmer No. *3632*

P. O. Address *Springfield, Mo.*

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.