

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023548

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1678

AMENDED

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS		Length of stay in 1b 19 DAYS	c. CITY OR TOWN LESLIE Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOSP VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE #1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROBERT Middle T Last MITCHELL			4. DATE OF DEATH Month JUNE Day 13 Year 1961			
5. SEX 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 1-27-89	9. AGE (last birthday) 72	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) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) ELESBERRY, MO.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME ROBERT D. MITCHELL	13b. MOTHER'S MAIDEN NAME SARAH TRAIL	14. NAME OF HUSBAND OR WIFE ELLENORA CARPENTER	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	16. SOCIAL SECURITY NO.	17. INFORMANT PAULINE BENEAR, NIECE, 3805 MAFFIT AV., Address ST LOUIS, MO.
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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:		INTERVAL BETWEEN ONSET AND DEATH 20 DAYS
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		UNDETERMINED
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) GENERALIZED ARTERIOSCLEROTIC HEART DISEASE	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. CHRONIC BRONCHITIS, 2. EMPHYSEMA		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 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 Hour VA Month, Day, Year 5-25-61	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 **5-25-61** to **6-13-61**
Death occurred at **4:00 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Emmett D. Wall (Degree or title) <i>Emmett D. Wall M.D.</i>	22b. ADDRESS VAH JEFFERSON BARRACKS, MISSOURI	22c. DATE SIGNED 6-13-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE June 15, 1961	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Memorial	23d. LOCATION (City, town, or county) (State) Sullivan, Mo. u
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24. FUNERAL DIRECTOR H. M. Eaton ADDRESS Sullivan, Mo.	25. DATE RECD. BY LOCAL REG. 6-16-61	26. REGISTRAR'S SIGNATURE <i>John C. Mumfry M.D.</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 Harrison W. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, 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.