

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024341

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 316

Primary Registration District No. _____

Registrar's No. 261

FILED JUN 19 1962

VS 300
Rev. 4/59

1 0940

2 0940

3 2

4 0

5 1

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7 0

8 2

9 94200

10

11

12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) Cantwell		Length of stay in lb 21 years.	c. CITY OR TOWN Cantwell
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Cantwell
3. NAME OF DECEASED (Type or print) First James Middle Clardy Last Mitchell		4. DATE OF DEATH Month June Day 12 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1882 - 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Lead Company	11. BIRTHPLACE (City and state or country) Bismarck, Missouri
13a. FATHER'S NAME George Calvin Mitchell		13b. MOTHER'S MAIDEN NAME Sarah Ann Cole	14. NAME OF HUSBAND OR WIFE Ethel Williams Mitchell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Houck Mitchell, Flat River, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction Arteriosclerotic heart disease and Arterial hypertension DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 30 min known for 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Asthma			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 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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION		COUNTY _____	STATE _____
21. I attended the deceased from <u>1957</u> , to <u>June 12, 62</u> and last saw him alive on <u>June 10, 1962</u> Death occurred at <u>4 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. L. Foster M.D.</u> (Degree or title)		22b. ADDRESS <u>Desloge Mo</u>	22c. DATE SIGNED <u>6-14-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/15/1962	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	23d. LOCATION (City, town, or county) (State) St. Francois, Mo.
24. FUNERAL DIRECTOR C.Z. Boyer & Son		25. DATE REC'D. BY LOCAL REG. <u>June 14, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>

JUN 21 1962

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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Des Moines 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.