

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH **63-035643**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 193 STATE FILE NUMBER

~~FILED~~ **OCT 10 1963**

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		c. CITY OR TOWN <u>Hornersville</u>	
Length of stay in 1b <u>few min.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hiway 26 by pass</u>		d. STREET ADDRESS <u>6 miles N.E.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Debra Diane Mitchell</u>			4. DATE OF DEATH Month Day Year <u>Oct 1 1963</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>cauc.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 23, 1962</u> yr
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state of country) <u>Malden Mo.</u>
13a. FATHER'S NAME <u>James Ray Mitchell</u>		13b. MOTHER'S MAIDEN NAME <u>Priscilla R. Parker</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Adell Mitchell, Parma Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Contusions, scalp, face & chest</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute hemorrhagic pneumonitis due to ingestion of kerosene.</u>			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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT: SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>while being taking to hospital in ambulance</u>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year <u>7:30 p.m. 10-1-63</u>	<u>due to ingestion of kerosene, ambulance was struck by 2 other cars.</u>		
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>Kennett</u>	COUNTY <u>Dunklin</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>7:30 P.M.</u> to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Cause or title) <u>Quinton Tarver, Coroner</u>		22b. ADDRESS <u>Kennett, Mo.</u>	22c. DATE SIGNED <u>10-7-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Oct. 30, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) <u>Malden Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Watkins and sons Parma, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-7-1963</u>	REGISTRAR'S SIGNATURE <u>Earl H. Hunsman</u>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1961 OCT 11

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 *[Handwritten Signature]*

Licensed Embalmer No. 4964

P. O. Address *[Handwritten Address]*

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.