DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33799

Registration District No. 7911 (NOV 16 1940)

Primary Registration District No. 1003

Registrar's No. 8496

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Charleston NR (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME William Davis Mitchell

3. (b) If veteran, name war No.

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Evelyn

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased April (Month) 22 (Day) 1868 (Year)

8. AGE: Years 72 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Livingston (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Hotel Manager

11. Industry or business

MOTHER FATHER

12. Name David Mitchell

13. Birthplace (City, town, or county) Kentucky (State or foreign country)

14. Maiden name Nancy Jane Edwards

15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant's own signature Mrs. Evelyn Mitchell

(b) Address Charleston, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/13/40 (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Albert H. Honne

(b) Address 4700 Washington Ave.

19. (a) OCT 14 1940 (Date received by local registrar) (b) J. F. Burdick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11 year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from 10-6, 1940, to 10-11, 1940 that I last saw him alive on 10-11, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary thrombosis	6 hrs
Due to Infarction of myocardium	5 wks
Due to Arteriolar nephrosclerosis	3 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations No

Of autopsy Confirms above findings

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PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Howard R. Bierman, M.D. (M. D. or other)

Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

APR 12 1943

APR 19 1943

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.