

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

36386

1. PLACE OF DEATH

County Andrew
Township Shobview
City _____ (No. _____)

Registration District No. 230
Primary Registration District No. 5313

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

James Hugh Mitchell

(a) Residence No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of Mary E. Mitchell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31 1887

7. AGE YEARS 69 MONTHS 4 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Franklin Co Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known (STATE OR COUNTRY)

14. INFORMANT John Mitchell (Address) R.R. 2 Steelville Mo.

15. FILED Dec 27 1927 J. P. A. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 1927

17. I HEREBY CERTIFY That I attended deceased from June 1927 to Dec 21 1927 that I last saw him alive on Nov 17 1927, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial Nephritis.
1 1/2 (duration) yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY) 1290 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) William J. Green, M. D.
12/22, 1927 (Address) St James Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Green Cemetery DATE OF BURIAL Dec 23 1927

20. UNDERTAKER Jonas and Tim Ayck ADDRESS St. James Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

17 1927

