

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.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 Weeks
 (Specify whether _____)
 In this community _____
Unknown
 years, months or days)

3. (a) PRINT FULL NAME Hettie S. Mitchell **324**
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife James A. Mitchell (deceased)
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased October 9, 1862
 (Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 14
 If less than one day hr. _____ min. _____

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

10. Usual occupation At home

11. Industry or business _____

FATHER
 12. Name Robert F. Keown
 13. Birthplace Illinois
 (City, town, or county) (State or foreign country)

MOTHER
 14. Maiden name Martha Brown
 15. Birthplace Tenn.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Herbert E. Mitchell
 (b) Address 4356 Lee Ave

17. (a) Burial (b) Date thereof 12/26/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park

18. (a) Signature of funeral director Math Hermann & Son
 (b) Address 2161 East Fair Ave

19. (a) DEC 26 1939 (b) J. F. [Signature]
 (Received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis **10**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3832 Penrose St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 23
 year 1939 hour 1:15 PM minute _____ M. _____

21. I hereby certify that I attended the deceased from November 5,
1939, to December 23, 1939
 that I last saw her alive on December 23, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive arteriosclerotic heart disease
Renal

Due to _____
 Due to _____

Other conditions Arteriosclerotic Renal
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Walter Ford (M. D. or other) _____
 Address St Louis City Hoop Date signed 12 26 39
1515 Lafayette,

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 *Roman Hampton*
Licensed Embalmer No. 2967
P. O. Address *St. Louis, 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 this body is not embalmed, above space should be left blank.