

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. 7911 Primary Registration District No. 1003

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: Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community 40 years
years, months or days)

8. (a) PRINT FULL NAME Carl Mitchell
8. (b) If veteran, name war Unk
8. (c) Social Security No. Unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 78 Months . Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business Unk

MOTHER FATHER
12. Name Unk
18. Birthplace Unk
(City, town, or county) (State or foreign country)
14. Maiden name Unk
15. Birthplace Unk
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Florence A Spotta
(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 8-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washingtn D

18. (a) Signature of funeral director W. R. Rosten
(b) Address 3100 Rosten

19. (a) SEP 3 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL") 2/
(d) Street No. 3044 Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 20
year 1940 hour 11:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 12, 1940, to August 20, 1940, that I last saw him alive on August 20, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia Broncho Uremia
Duration 36 hrs 3 days

Due to Chronic Nephritis; Arterioscle- Indef
rotic Heart Disease; Indolent
Due to Ulcers of both legs

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 131
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 E. A. Mc Dowell (M. D. or other)
Address 2601 N Whittier Date signed _____

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.....

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