

No. 2
-1-4-41
-17-39.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39802

FILED JAN 24 1941
Registration District No. 194291

State File No. _____

Primary Registration District No. 1003

Registrar's No. 9508

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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether
In this community 4 hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. Came from Train
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jim Mitchell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 18, 1887
(Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Aaron Mitchell

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

14. Maiden name Mae Hart

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

16. (a) Informant Shirley Smith
(b) Address 2601 N. Whittier

17. (a) _____ (b) Date thereof 11-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) DEC 1 1941 (b) J. P. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21, 1941
year _____ hour 11 minute 44 A. M.

21. I hereby certify that I attended the deceased from Nov. 5, 1941
to Nov. 21, 1941.
that I last saw him alive on November 21, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration Unk.

Due to _____

Due to _____

Other conditions. (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 J. W. Johnson (M. D. or other) _____

Address 2601 Whittier St. Date signed 1-25-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.