

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15531

State File No. _____

Registrar's No. 910

Registration District No. 7842

Primary Registration District No. 20

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos. + 4 days
(Specify whether
In this community 18 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2675c Washington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1942 hour 12 minute 55 P.M.

21. I hereby certify that I attended the deceased from December 16, 1941, to April 20, 1942
that I last saw him alive on April 20, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic pulmonary tuberculosis
Duration months and years

Due to 13/1

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Intestinal tuberculosis

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 Francis H. Steubing (M. D. or other) M.D.
Address Robert Koch Hospital Date signed 5-2-42

3. (a) PRINT FULL NAME David Mitchell

3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-07-1563

4. Sex male 5. Color or race Negro 6. (a) Single, widowed, married, divorced, separated

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

7. Birth date of deceased October 26, 1901
(Month) (Day) (Year)

8. AGE: Years 40 Months 5 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Bellhop

11. Industry or business _____

12. Name David Mitchell

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

14. Maiden name Estelle Marshall

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

16. (a) Informant Hospital Record

(b) Address Koch

17. (a) Removal (b) Date thereof 4-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ark

18. (a) Signature of funeral director J. H. Randle & Son

(b) APR 24 1942

19. (a) _____ (b) E. J. McFarland
(Date received local registrar) (Registrar's signature)

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

27-42

11 C 99

APR 28 1942

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..... *S. J. Watson*
Licensed Embalmer No. *269*
P. O. Address *2769 Shorten*

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.