

S. No. 2
DM-5-42
v. 5-17-39
I X32873

23522

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 19 1942

3023

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

48
838

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.C. General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 38

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2414 Chestnut
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Kathryn Mitchell

MEDICAL CERTIFICATION

3. (b) If veteran, name war 760

3. (c) Social Security No. None

20. DATE OF DEATH: Month August day 10th
year 1942 hour 5:00 A.M. minute 0 M.

4. Sex Female Color White (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Thomas J. Mitchell (c) Age of husband or wife if alive 17 years

7. Birth date of deceased Nov 17, 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 5th 1942 to August 10th 1942;
that I last saw her alive on August 10th 1942, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction with post operative hemorrhage

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>4</u>	<u>23</u>	hr. min.

Due to 1223

9. Birthplace Pittsburg Pa 1
(City, town, or county) (State or foreign country)

Due to

10. Usual occupation at home

Other conditions None
(Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Low intestinal obstruction

12. Name Patrick M. Thomas

Of operations Low intestinal obstruction

13. Birthplace Douglas 4
(City, town, or county) (State or foreign country)

Of autopsy None

14. Maiden name Mary Ann

15. Birthplace Douglas 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary A. Thomas

22. If death was due to external causes, fill in the following:

(b) Address 2414 Chestnut

(a) Accident, suicide, or homicide (specify)

17. (a) Removal (b) Date thereof 8-12-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence

(c) Place: burial or cremation St. Marys

(c) Where did injury occur?

18. (a) Signature of funeral director Thomas G. Smith
(b) Address 2316 Brook ave

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

19. (a) 8-11-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

23. Signature Mary R. Shaw (M. D. or other) 0
Address Med. Dir. K.C. General Hospital 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..... *Thomas J. Jank*

Licensed Embalmer No..... *3775*

P. O. Address..... *F. O. 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

3023

Registration District No.

Primary Registration District No.

Registrar's No.

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Kathryn Mitchell

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 8/11/42 (b) M. D. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No. 2414 Chestnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10th
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death
Intestinal obstruction
with P. O. hemorrhage

Due to Cause unknown

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-23522

SECRET

CONFIDENTIAL

CONFIDENTIAL