

FILED JUN 12 1943

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Houston
(c) Name of hospital or institution: State Hosp. No. 1
(d) Length of stay: 6-28-43

In this community _____
years, months or days

3. (a) PRINTED FULL NAME William Mitchell

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

4. Sex M 5. Color Black 6. (a) Single, widowed, married, divorced DK

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

7. Birth date of deceased DK DK 1949
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation labor

11. Industry or business _____

MOTHER FATHER { 12. Name Bryan Mitchell
13. Birthplace Ala (City, town, or county) (State or foreign country)
14. Maiden name Rachel Mitchell
15. Birthplace Ala (City, town, or county) (State or foreign country)

16. (a) Informant Record

(b) Address _____
17. (a) Removal (b) Date thereof 5-10-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia MO

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia MO

19. (a) 5-10-1949 (b) Joie Moraukoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scott
(c) City or town Houston
(d) Street No. DK
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1943 hour L minute 58 A. M.

21. I hereby certify that I attended the deceased from 11-20-1942 to 5-6-1943
that I last saw him alive on 5-6-1943
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myo carditis

Due to _____

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 J. E. Estherville (M. D. or other) _____
Address Houston MO Date signed 5/10/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

14
1
2

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.