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39
26390

FILED FEB 22 1944
Registration District No. 2234

Primary Registration District No. 5299

State File No. _____

Registrar's No. 4

1. PLACE OF DEATH:

(a) County MONROE
(b) City or town RURAL - MARION TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 1/2 MI. S. OF HOLLIDAY
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 34 YRS years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County MONROE-69
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 MI. S. OF HOLLIDAY
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 14
year 1944 hour 9 minute 30 A. M.
21. I hereby certify that I attended the deceased from Oct. 2 - 1943
19____ to Oct 29 1943
that I last saw him alive on Oct 29 1943
and that death occurred on the date and hour stated above.

Immediate cause of death:
acute myocardial failure Duration 6 mo
Due to chronic poisoning ✓

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 F.A. Burnett (M.D. required) MD
Address PARIS, MO. Date signed 1-14-44

3. (a) PRINT FULL NAME EDWARD C. MITCHELL

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

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

6. (b) Name of husband or wife LILLIE M. MITCHELL 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased AUG. 10 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 4 If less than one day hr. _____ min. _____

9. Birthplace MONROE Co. Mo. A
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name GARLAND C. MITCHELL

13. Birthplace OLDHAM CO. KY. I
(City, town, or county) (State or foreign country)

14. Maiden name VIRGINIA BIERLY

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

16. (a) Informant Lucile S. Mitchell
(b) Address HOLLIDAY, MO.

17. (a) BURIAL (b) Date thereof JAN. 15, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MADISON, MO

18. (a) Signature of funeral director SPEED • BLAKET
(b) Address PARIS, MO

19. (a) 1-15-44 (b) Otis Hedberg
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-275

Date Filed FEB 5 1944

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 W. H. Blakey
Licensed Embalmer No. 2614
P. O. Address Paris, 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.

FEB

5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 226

Primary Registration District No. 5799

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Rural Monroe, La.
(If outside city or town limits, write "RURAL" and name of town)

(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 Edward C. Mitchell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 10 1910
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days _____
If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1946 hour _____ minute _____ M.

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

Immediate cause of death acute myocardial infarction

Due to Uremic Poisoning 6 Mo from Prostatic Hypertrophy

Due to (It did not follow chronic nephritis)

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? No (Specify type of place) _____ (e) Means of injury _____

23. Signature J. A. Barnett (M. D. or other) _____
Address Paris, Mo Date signed 2-9-46

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

MOTHER FATHER

SUPPLEMENTAL

3651