

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26456

State File No.

Registrar's No.

7269 ✓

FILED SE 8 1944
Registration District No. 1318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital
(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 Elijah Parks Mitchell3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unk. years
 7. Birth date of deceased July 14 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	1	5	hr. min.

9. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Railroad Fireman11. Industry or business Railroad

MOTHER FATHER
 12. Name Price Mitchell
 13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown U. terback
 15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Harley Mitchell
(b) Address Springfield, Ill.17. (a) Removal (b) Date thereof 8-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Ill.18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Blvd.19. (a) AUG 21 1944 (b) J. F. Beedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 306 Lami
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1944 hour 3:00 minute P. 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
Cardiac Hypertrophy; Chronic
Pyelonephritis; Chronic Cholecystitis
 Due to with Lithiasis;

Due to 134 a
 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 3
(Specify type of place) (Means of injury)23. Signature Thomas F. Callahan
Address Deputy Coroner Date signed 8-21-44

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. Wilkin*.....
Licensed Embalmer No..... *3575*.....
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.