

Registration District No. 56-

Primary Registration District No. 3011

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(c) Name of hospital or institution:
609 W Benton st
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community many years
years, months or days)

3. (a) PRINT FULL NAME WILLIAM H. 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 Married

6. (b) Name of husband or wife Lizzie Richard 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Apr 30 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business

12. Name James Mitchell
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Morgan
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Virginia Mitchell
(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 11-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagnotter Cem

18. (a) Signature of funeral director Stanley
(b) Address Carrollton Mo

19. (a) 11-3-44 (b) Mrs James Paffety
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Carrollton
(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 Nov day 1
year 1944 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan. 14
1944, to Nov 1 1944

that I last saw him alive on Oct. 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure

Due to Chronic Nephritis

Due to Chronic Prostatitis

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

Major findings:

Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration

6 mos

8 mos

14 mos

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) Manner of injury g

23. Signature Dr. Everett L. Smith (M. D. or other) _____
Address 11 de Main, Carrollton, Mo Date signed 11/2/44

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

12-8-47

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 _____

Ben W Gibson

Licensed Embalmer No. _____

2961

P. O. Address _____

Carrollton 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.

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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

Wm H. 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 _____

7. Birth date of deceased April 30 1910
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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)
(Burial, cremation, or removal)

(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 Nov year 1946 day _____ 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 Congestive Heart Failure

Due to Chronic Nephritis Chronic Prostatitis

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 12/1

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

37425