

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 149

Primary Registration District No. 1002

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:
2110 East 35th St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 50 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2110 East 35th St
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert S. Mitchell

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

4. Sex Male 5. Color or race Wh

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

6. (b) Name of husband or wife Alice F. Mitchell

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Aug 4th 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2nd
year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 25 1944
5:30 to 11:30 1944
that I last saw him alive on Nov 25 1944
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>4</u>	<u>28</u>	hr. <u> </u> min. <u> </u>

Immediate cause of death Chor. Myocarditis **5 yrs**

Due to Chor. Myocarditis **3y**

Due to Chor. Myocarditis **3y**

Other conditions Chor. Myocarditis

(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired Sheet Metal Worker

Major findings:
Of operations Chor. Myocarditis

Of autopsy 12/18

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business

MOTHER FATHER

12. Name D. M. Mitchell

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Alice F. Mitchell

(b) Address 2110 East 35th St

17. (a) Burial (b) Date thereof Dec 4th 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brooking Cemetery

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?

18. (a) Signature of funeral director Clyar Funeral Home

(b) Address Kansas City Missouri

19. (a) Dec 7 1944 (b) J E Brown
(Date received local registrar) (Registrar's signature)

(c) While at work? (Specify type of place) (e) Means of injury

23. Signature J E Brown (M. D. or other)

Address 926 Mc Lane Date signed 12/21/44

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

Dr. K. R. Barnum
926 McGee
V12922

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. *4063*

P. O. Address. *1800 Linwood Blvd.*

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.