

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3179

State File No. _____

FILED FEB 14 1945

Registration District No. 297

Primary Registration District No. 6022

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond, Mo. Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
In this community All His Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray

(c) City or town Richmond, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.# 2
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country U.S.A.

3. (a) PRINT FULL NAME LEE F. MITCHELL

3. (b) If veteran, name war None

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8th
year 1945. hour 11 minute A. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Josephine (Blain) Mitchell - Alive

6. (c) Age of husband or wife if Alive

7. Birth date of deceased July 24th 1862.
(Month) (Day) (Year)

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

Immediate cause of death CORONARY ARTERIOSCLEROSIS Duration _____

8. AGE: Years 82 Months 5 Days 15
If less than one day _____ hr. _____ min.

Due to Death Sudden.

Due to _____

9. Birthplace Ray Co. Missouri.
(City, town, or county) (State or foreign country)

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

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

12. Name Geo. W. Mitchell

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

14. Maiden name Heneriva Tucker
(City, town, or county) (State or foreign country)

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Walter Mitchell

(b) Address Richmond, Mo.

17. (a) Burial (b) Date thereof 1-10-45.
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation South Point

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? _____

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

18. (a) Signature of funeral director J.B. Brothers
(b) Address Richmond, Mo.

19. (a) Jan 13 1945 (b) Mo. Charles Sheppard
(Date received local registrar) (Registrar's signature)

23. Signature J.F. Baber 3 Coroner
(M.D. or other) (Date signed) 1-8-45

Address Richmond Mo

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

RECEIVED

Public Health Officer No. 8,

District File Number

Date Filed

2-13-45

OFF

IF

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

working under my personal supervision.

Registered Apprentice No.

Brothers Funeral Home

Signed

Carlton Minor

Licensed Embalmer No. 1313414

P. O. Address. Richmond ? Missouri.

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. 297

Primary Registration District No. 6022

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond RURAL
(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 Lee J. 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 July 24 1906
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Day _____ If less than one day _____ min.

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

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)

(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 _____ year 1944 hour 4 minute 5 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

3179