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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.

FILED APR 10 1945

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Camden
(b) City or town Caruthersville
(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 (Specify whether)
In this community 4 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Camden
(c) City or town Caruthersville 78
(If outside city or town limits, write "RURAL")
(d) Street No. 500 Grand Ave 1
(If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U.S.A.

3. (a) PRINT FULL NAME

Louis Mitchell

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
6. (b) Name of husband or wife None

6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive None years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 83 hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
12. Name Unknown ?
13. Birthplace Unknown ?
(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 Mary Byrd

(b) Address Caruthersville, Mo

17. (a) Burial (b) Date thereof 3-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville, Mo

18. (a) Signature of funeral director Paul C. Dean

(b) Address Caruthersville, Mo

19. (a) 3-5-1945 (b) Jessie N. Markey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1945 hour 8 minute 45 A.M.

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

Immediate cause of death NOT DETERMINED. Duration _____

NO ATTENDING PHYSICIAN

Due to _____

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 _____ (Specify type of place)
(b) Means of injury _____

23. Signature Fred L. Ochs (M. D. or D.V.M.)
Address Caruthersville, Mo H. OFFICER Date signed 3-5-45

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

3-45-77

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 Noel C. Dean

Licensed Embalmer No. 3941

P. O. Address Cantherville

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.

State File No. April
Registrar's No. 28

Registration District No. 270 Primary Registration District No. 3060

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

1. PLACE OF DEATH:

(a) County Pemissot
(b) City or town Carthageville
(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 Louis Mitchell

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: after 83 Years _____ Months _____ 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 March year 1941 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 _____

Duration _____

SUPPLEMENTARY
I have no additional information except as given in original certificate
PHYSICIAN
Underline the cause to which death should be charged statistically.
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Due to _____

Due to _____

Other condition _____ (Include diagnosis, date, and results 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) _____ (Means of injury)

23. Signature Fred. Ogilvie 25 (M. D. or other) _____

Address _____ Date signed _____

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