No. 2
1—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 11 1945

State File No. 22320

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6937

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: ST LUKES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 WEEKS (Specify whether
In this community 1 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RIPPLEY 91

(c) City or town 0
(If outside city or town limits, write "RURAL")

(d) Street No. NR 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME EMIS MITCHELL

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife DORA BELL

6. (c) Age of ~~husband~~ or wife if alive 73 years

7. Birth date of deceased APRIL (Month) 22 (Day) 1869 (Year)

8. AGE: Years 76 Months 3 Days 9 If less than one day hr. min.

9. Birthplace McKRACKEN Co (City, town, or county) Ky 1 (State or foreign country)

10. Usual occupation FARMER

11. Industry or business RETIRED

FATHER
12. Name NEELY MITCHELL
13. Birthplace UNKOWN (City, town, or county) Ky 1 (State or foreign country)

MOTHER
14. Maiden name UNKOWN
15. Birthplace UNKOWN (City, town, or county) 9 (State or foreign country)

16. (a) Informant MACY MITCHELL
(b) Address 7573 AHERN AV

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-4-1945 (Month) (Day) (Year)
(c) Place: burial or cremation NAYLOR MO

18. (a) Signature of funeral director ROWLAND MORTUARY
(b) Address 4355 WASHINGTON AV

19. (a) AUG 7 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 1st year 1945 hour 7 minute 30 p.M.

21. I hereby certify that I attended the deceased from May 28, 1945 to Aug. 1, 1945 that I last saw him alive on Aug 1, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	2½ mo.
Due to: Arteriosclerosis	yrs.
Due to:	
Other conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	?

Major findings:
Of operations 61

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. W. Lutner (M. D. ~~or other~~)
Address 3720 Washington Ave Date signed 8-2-45

(Licensed Embalmer's Statement on Reverse Side)

6937

6937

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 John Ketter

Licensed Embalmer No. 3880

P. O. Address St Louis, 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.

. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22824

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6937

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

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ripley
(c) City or town Naylor
(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

3. (a) PRINT FULL NAME Eris 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
7. Birth date of deceased Apr 22 1868 (Month) (Day) (Year)
8. AGE: Years 76 Months 3 Days If less than one day hr. 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) (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) OCT 15 1945 (Date received local registrar) (b) J. F. Breeden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1945 hour minute 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.

	Duration
Immediate cause of death	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1945

S-22320