

**FILED DEC 7 1945**  
42

Registration District No. 42 Primary Registration District No. 1000

Registrar's No. 1226

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

1. PLACE OF DEATH:

(a) County... Buchanan

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

(c) Name of hospital or institution: Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution... 3 days (Specify whether years, months or days)

In this community... 3 days

3. (a) PRINT FULL NAME John H. Mitchell

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy Mitchell 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased May 2 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>6</u>	<u>13</u>	hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name Garrett - Mitchell

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

14. Maiden name Hizzie Lane

15. Birthplace Buchanan Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Mitchell

(b) Address Plattsburg Mo

17. (a) Burial (b) Date thereof Nov 17 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frazier Mo

18. (a) Signature of funeral director N. A. Sullivan

(b) Address G. A. W. S. Mo

19. (a) Nov 20 1945 A. J. Nestlebusch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

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

(d) Street No. 1 mi South Plattsburg  
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION NOVEMBER 15th

20. DATE OF DEATH: Month November 15 day

year 1945 hour 8 minute 40 P.M.

21. I hereby certify that I attended the deceased from Nov 13 4:15 to Nov 15 1945

that I last saw him alive on Nov 15 1945

and that death occurred on the date and hour stated above.

Immediate cause of death: Abdominal ad. lesions  
intestinal obstruction

Due Gangrene of ileum  
Peritonitis, general

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: As above

Of operations

Of autopsy 129

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 A. J. Nestlebusch M.D. (M. D. or other M.D.)

Address St. Joe's Mo Date signed 11-15-45

Duration ?

11-9-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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 H. A. Sullivan  
Licensed Embalmer No. 1738  
P. O. Address Gower 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.**