

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Lemmon  
State File No. 19993  
Registrar's No. 481

FILED JUL 1 1946

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:  
(a) County... Springfield  
(b) City or town... Greene  
(c) Name of hospital or institution... St. John's Hosp. 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution... 4 Days  
In this community... 2 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME... Thomas L. Mitchell  
3. (b) If veteran, name war... No  
3. (c) Social Security No... No

4. Sex... Male 0  
5. Color or race... White  
6. (a) Single, widowed, married, divorced... Married  
6. (b) Name of husband or wife... Maude Mitchell  
6. (c) Age of husband or wife if alive... 65 years  
7. Birth date of deceased... Feb. 16, 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 3 21 hr. min.

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

10. Usual occupation... Retired  
11. Industry or business... Locomotive Engineer

MOTHER FATHER

12. Name... James Thomas Mitchell  
13. Birthplace... Lisman Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name... Mary Jane Boulard  
15. Birthplace... Princeton Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant... Maude Mitchell  
(b) Address... Springfield, Mo.  
17. (a) Removal... (b) Date thereof... 6/8/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation... Princeton, Ky.

18. (a) Signature of funeral director... H.H. Lohmeyer  
(b) Address... Springfield, Mo.

19. (a) 6-10-46 (b) Dr W J Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State... Missouri (b) County... Greene 39  
(c) City or town... Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No... 827 S. Grant  
(If rural, give location)  
(e) Citizen of foreign country?... (Yes or No) 0  
If yes, name country...

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7  
year 1946 hour 6:00 minute P. M.  
21. I hereby certify that I attended the deceased from 5-31 1946 to 6-7 1946  
that I last saw him alive on 6-7 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death... Coronary thrombosis, acute  
Duration

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 work? (Specify type of place)  
(e) Means of injury  
23. Signature... Bruce Lemmon M. D. or other  
Address... 600 Med Arts, Springfield, Mo. 6-10-46

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

9  
2  
6

18867

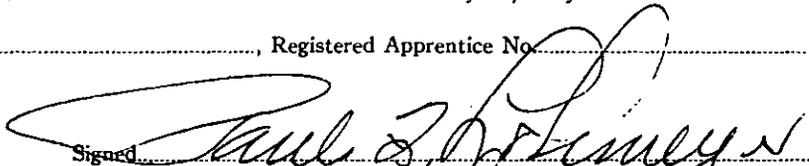
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**STATEMENT BY LICENSED EMBALMER**

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 

Licensed Embalmer No. 24507

P. O. Address Marysville, 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.**

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