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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13, 1947

Registration District No. 178

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24666

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede County

(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Wallace Memorial 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 Hrs. (Specify whether
In this community 42 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede 53

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

(d) Street No. Sleeper Rt. I 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ursel B. Mitchell

3. (b) If veteran, name war

3. (c) Social Security No. 398-05-0015

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 5 (Day) 1905 (Year)

8. AGE: Years 42 Months 1 Days 22 If less than one day hr. min.

9. Birthplace Laclede Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation laborer

11. Industry or business

FATHER
12. Name W. H. Mitchell
13. Birthplace Camdenton (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Eliza Goodin
15. Birthplace Laclede Co (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Adam E. Mitchell
(b) Address Lebanon Rt. 3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Goodwin Cemetery

18. (a) Signature of funeral director Palmer's
(b) Address Lebanon, Mo

19. (a) Aug 2, 1947 (Date received local registrar) (b) Orq Frankeberger (Registrar's signature) 1.5

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1947 hour 2 minute P.M.

21. I hereby certify that I attended the deceased from July 20, 1947, to July 26, 1947; that I last saw him alive on July 20, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Shock — Duration 16 hrs.

Due to Sucking wound of left thorax — 16 hrs.

Due to Undetermined accidental causes.

Other conditions
(Include pregnancy within 3 months of death)

195 F
40

Major findings:
Of operations Left thorax crushed, sucking wound
Of autopsy Not done

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) accident 53

(b) Date of occurrence July 25, 1947

(c) Where did injury occur? Lebanon (City or town) Laclede (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place? R.R. right of way
(Specify type of place)

While at work? ? (e) Means of injury ? 0

23. Signature H W Carrington (M. D. or other) M.D.
Address Lebanon, Mo. Date signed 7/29/47

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Registration District No. ____ Primary Registration District No. ____ State File No. ____

Received 8/9/47

Laclede County Health Unit

File No. 7-47-129

Date Filed 8/12/47

1. PLACE OF DEATH:
(a) County ____
(b) City or town ____
(If outside city or town limits, write "RURAL" or 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. (a) PRINT FULL NAME ____

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

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

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: Years ____ Months ____ Days ____ If less than one day ____ hr. ____ min.

9. (a) USUAL RESIDENCE OF DECEASED:
(a) State ____
(b) City ____
(c) Street ____
(d) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ Day ____ Year ____ Hour ____

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 ____

10. Usual occupation ____ (City, town, or county) (State or foreign country)

11. Industry or business ____

12. (a) Name ____ (b) Birthplace ____

13. (a) Maiden name ____ (b) Birthplace ____

14. (a) Date of death ____ (b) Date buried ____

15. (a) Place of death ____ (b) Place buried ____

16. (a) Informant ____ (b) Address ____

17. (a) Signature ____ (b) Address ____

18. (a) Date received by local registrar ____ (b) ____

19. (a) Date received by State Registrar ____ (b) ____

(Licensed Embalmer's Statement on Reverse Side)

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 S. R. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon, 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.

WHITE LEGAL—USE DENOTING BLACK INK—MAKE A LEGIBLE RECORD