No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30343

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 238

1. PLACE OF DEATH:

(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days (Specify whether years, months or days)
In this community 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Texas 107
(c) City or town: Mountain Grove 0
(If outside city or town limits, write "RURAL")
(d) Street No.: R. #1 0
(If rural, give location) 1
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Jesse Franklin Mitchell

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

4. Sex: M 0
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married 1
6. (b) Name of husband or wife: Serilda Mitchell
6. (c) Age of husband or wife if alive: 62 years
7. Birth date of deceased: 4-20-'74 (Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 29 If less than one day hr. min.

9. Birthplace: Near Hartsville (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation: Farming
11. Industry or business:

MOTHER FATHER
12. Name: Jesse Mitchell 4
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
14. Maiden name: Unknown 4
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: MRS. Jesse Mitchell
(b) Address: R#1, Mountain Grove, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Hartville Mo
18. (a) Signature of funeral director: Parker Funeral Service
(b) Address: Columbia Mo
19. (a) 9-10-47 (Date received local registrar) (b) Mrs. R. E. Palmer (Registrar's signature) 21

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9 year 1947 hour 1:15 minute ~~A.M.~~ P.M.

21. I hereby certify that I attended the deceased from March 19, 1947, to Sept. 9, 1947, that I last saw him alive on Sept. 9, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia — Duration: 5 da.
Due to:
Due to: CTP
Other conditions: Carcinoma of Larynx
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma of Larynx, post-irradiation recurrence
Of autopsy: Extensive necrotizing bronchopneumonia

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: 0

23. Signature: John Modlin M.D. (M. D. or other) M.D.
Address: State Cancer Hospital, Columbia, Mo. Date signed 9-10-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 9-29-42

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 Thos. L. Laring

Licensed Embalmer No. 4132

P. O. Address Columbia, 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.