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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

6781

FILED MAR 15 1948  
Registration District No. 318

Primary Registration District No. 1003

State File No. 2400  
Registrar's No.

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos 24 days  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3900 W Bell  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar. day 4  
year 1948 hour 7 minute a. m.

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Vaughn Mitchell  
6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased July 6 1900  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
Nov. 11 19 47 to Mar. 4 19 48  
that I last saw her alive on Mar. 4 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Carcinoma of Cervix, Advanced  
Duration Undet.

8. AGE: Years Months Days If less than one day  
47 7 28 hr. min.

Due to  
Due to  
Other conditions None  
(Include pregnancy within 3 months of death)

9. Birthplace Augusta, Arkansas  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations  
Of autopsy No

10. Usual occupation Domestic

PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name Henry Wells

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

14. Maiden name Alice Dehart  
15. Birthplace Augusta, Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Wells

(b) Address 3900 West Belle Avenue

17. (a) Burial (b) Date thereof 3-10-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) MAR 9 1948 (b) J. J. Braddock  
(Date received local registrar) (Registrar's signature)

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) ( ) Means of injury  
23. Signature J. Newton [Signature] (M. D. or other)  
Address 2601 N Whittier Date signed 3/5/48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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.....

John K. Cunningham

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*John K. Cunningham*

..... Licensed Embalmer No..... 4476

P. O. Address..... 4107 Finney Aven

**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.**