

FILED APR 7 1948

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1003

Registrator's No. 2929

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Depaul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Lawrence A. Mitchell

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 8, 1948  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 17 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Albert L. Mitchell

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

14. Maiden name June Hitchcock

15. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert L. Mitchell

(b) Address 2707 Madison Str.

17. (a) Burial (b) Date thereof 3/26/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. F. Briscoe

(b) Address 2117 E. Grand Ave.

19. (a) MAR 25 1948 (b) J. F. Briscoe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2707 Madison Str.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 25  
year 1948 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from Mar 8  
1948 to Mar 25 1948  
that I last saw him alive on Mar 24 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Ulcerative Colitis Duration 12 da

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Acute Suppurative Peritonitis Ida  
(Include pregnancy within 3 months)

Major findings: Ulcerative Colitis Acute suppurative peritonitis PHYSICIAN \_\_\_\_\_

Of operations \_\_\_\_\_  
Of autopsy Ulcerative Colitis  
Acute suppurative peritonitis  
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) (c) Means of injury \_\_\_\_\_

23. Signature John G. McSwiney (M. D. or other) M.D.

Address 5014 Sheila Ave. Date signed 3/25/48

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

MOTHER, FATHER

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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.

*Not Embalmed*

Signed *Frank A. Moore*

Licensed Embalmer No. *3041*

P. O. Address. *2117 E. Grand*

**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.**