

No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 11 1949

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41685**
Registrar's No. **10950**

Registration District No. **318**

Primary Registration District No. **100**

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

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:
Enroute to Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
5 years _____) (Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Minnie Mitchell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col.

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

6. (b) Name of husband or wife. Joseph Mitchell

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased. October 9 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49	2	8	_____ hr. _____ min.
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9. Birthplace Kosciusko Miss
(City, town, or county) (State or foreign country)

10. Usual occupation domestic

11. Industry or business _____

12. Name Frank Eubanks

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

14. Maiden name unknown

15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Mitchell

(b) Address 2831 Dickson St.

17. (a) BURIAL (b) Date thereof. 12/21/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Washington Park Cem. T

18. (a) Signature of funeral director Ellis FUNERAL HOME

(b) Address 2820 Stoddard St

19. (a) DEC 20 1948 (b) J. B. Pasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2831 Dickson
21 (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17th
year 1948 hour _____ minute 30 AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death: Thrombotic Embolism Duration

fracture of left leg when she was

she was making bed being treated

by Dr. John Crowley, Swarthmore, Pa.

He threw her from her seat

on Nov 8, 1948

on a jump, she about 200 feet

high

included within 3 months of death

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Nov 8, 1948

(c) Where did injury occur? on jump
(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 fall

23. Signature Ellis Ferry (M. D. or other)

Address St. Louis Date signed 2/11/49

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.....

..... *James A. Carter*, Registered Apprentice No. *290*,
working under my personal supervision.

Signed..... *Fulton E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address..... *St. Louis*

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.