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FILED APR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12684
333-A

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>INDIANA</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield-Town S. Campbell Twp., Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Indianapolis</u>	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) <u>Unknown</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Medical Center for Federal Prisoners</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Samuel</u>	b. (Middle) <u>R.</u>	c. (Last) <u>Mitchell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 1950</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>June 14, 1930</u>	9. AGE (In years last birthday) <u>19</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Robert Mitchell</u>	13b. MOTHER'S MAIDEN NAME <u>Virgle Mitchell</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>10-25-45/7-25-47 307-24-9005</u>	17. INFORMANT'S SIGNATURE OR NAME <u>FILE M.C.F. P.</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Edema</u>		<u>Less than 7hr.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Insulin Shock diabetic (irreversible)</u> DUE TO (c) <u>Dementia Praecox paranoid type</u>		<u>7hr-40min.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>6mos. plus</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 14, 1949, to April 7, 1950, that I last saw the deceased alive on April 7, 1950, and that death occurred at 3:41 Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>E. C. Rinck</u> (Degree or title) <u>E. C. RINCK, M.D., CLINICAL DIRECTOR</u>	23b. ADDRESS <u>Medical Center for Federal Prisoners Springfield, Mo.</u>	23c. DATE SIGNED <u>4-13-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 21, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
DATE REC'D BY LOCAL REG. <u>4-20-50</u>	REGISTRAR'S SIGNATURE <u>W E Handley</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Paul C. Thome</u> ADDRESS <u>Springfield, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ralph H. Thier

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.