

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14811**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3480**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 30 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2932 Hickory St.	

3. NAME OF DECEASED (Type or Print) Robert Mitchell			4. DATE OF DEATH (Month) (Day) (Year) April 11 1950		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 23, 1890		9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Martin, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charlie Mitchell		13b. MOTHER'S MAIDEN NAME Sealy ?		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charlie Mitchell 3331 Laclede Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH Undet.
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined			
		DUE TO (c) None			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) St. Louis, Mo.		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 **3-19-1950**, to **4-11-1950**, that I last saw the deceased alive on **4-11-1950**, and that death occurred at **2:25 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Hedrick		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-11-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/17/50		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wright's Funeral Home 3100 Easton Ave.			
DATE REC'D BY LOCAL REG. APR 15 1950		REGISTRAR'S SIGNATURE J. B. Pasater			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Arthur L. Halliard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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.