No. 300
10.48

FILED SEP 16 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 32030
Registrar's No. 7904

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. Louis
c. LENGTH OF STAY (In this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Episc-Presb. Hosp

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrisburg
d. STREET ADDRESS (If rural, give location): R.1 - P.O. Box 117

812 0 8

**3. NAME OF DECEASED** (Type or Print)
a. (First): OPAL
b. (Middle):
c. (Last): Mitchell

**4. DATE OF DEATH** (Month) (Day) (Year): Aug. 25, 1954

**5. SEX**: F
**6. COLOR OR RACE**: Negro
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: 7-29-1912
**9. AGE** (In years last birthday): 42 — If under 1 year: Months / Days; If under 1 day: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Maid
**10b. KIND OF BUSINESS OR INDUSTRY**: Colonial Hotel
**11. BIRTHPLACE** (City and State or Foreign Country): Harrisburg, Ill
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13a. FATHER'S NAME**: John Rouse
**13b. MOTHER'S MAIDEN NAME**: Lucy Blackwell
**14. NAME OF HUSBAND OR WIFE**: Ollie Mitchell

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown)
(If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**: unk
**17. INFORMANT'S SIGNATURE OR NAME ADDRESS**: Georgia Blackwell, Harrisburg, Ill

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, Spontaneous Sub-Arachnoid — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Aneurysm, Saccular, Rt. Int. Carotid Artery

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**: 8/17/54
**19b. MAJOR FINDINGS OF OPERATION**: Aneurysm, Saccular Rt. Int. Carotid Artery
**20. AUTOPSY?** YES ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

452X

**22.** I hereby certify that I attended the deceased from 8-15, 1954, to 8-25-, 1954, that I last saw the deceased alive on 8-25, 1954, and that death occurred at 7 45A m., from the causes and on the date stated above.

**23a. SIGNATURE**: John W. Hand (Degree or title) M.D.
**23b. ADDRESS**: 7458 Calvin St. Louis 20, Mo
**23c. DATE SIGNED**: 8/26/54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 8/26/54
**24c. NAME OF CEMETERY OR CREMATORY**: Lakeview
**24d. LOCATION** (City, town, or county) (State): Carrier Mills, Ill.

**DATE REC'D BY LOCAL REG.**: AUG 26 1954
**REGISTRAR'S SIGNATURE**: J. Earl Smith, M.D.
**25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS**: Eugene Keathly, Harrisburg, Ill.

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

MAR 14 1959

## 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 Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.