

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012033

STATE FILE NUMBER

3352

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Missouri Pacific Hospital Association</i>		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Pacific Hospital Assn.</i>		Length of stay in 1b <i>2 Weeks</i>	d. STREET ADDRESS <i>6470 Devonshire Dr</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>John Bolton Mitchell</i>			4. DATE OF DEATH Month <i>March</i> Day <i>21</i> Year <i>1958</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 14, 1881</i>
9. AGE (In years last birthday) <i>76 years</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS. Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Superintendent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad Mo. Pac. R.R.</i>	11. BIRTHPLACE (City and state or country) <i>Lexington, Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13a. FATHER'S NAME <i>Wm. Z. Mitchell</i>	
13b. MOTHER'S MAIDEN NAME <i>Ary Ann Downtain</i>		14. NAME OF HUSBAND OR WIFE <i>Nelle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>702-16-1749</i>	
17. INFORMANT <i>Mrs. Nelle Mitchell</i>		Address <i>6470 Devonshire</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>578x</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hemorrhage from Gastro-intestinal tract of unknown cause</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>March 7/1958</i> to <i>March 21/1958</i> and last saw him alive on <i>March 21/1958</i> Death occurred at <i>5:10 P.M. March 21/1958</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Benjamin H. Chaskey, Jr. D.</i>		22b. ADDRESS <i>Mo. Pac. Hosp. Td - St. Louis</i>	22c. DATE SIGNED <i>22 March 1958</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>March 24, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Mausoleum</i>	23d. LOCATION (City, town, or county) (State) <i>7814 S. Charles Road St. L. 23, Mo.</i>
24. FUNERAL DIRECTOR <i>C. Hoffmeister Colonial Mortuary 6464 Chippewa St.</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 24 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>mjb</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard terminology. All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *Leiner C. Hoffmeister* .....

Licensed Embalmer No. *3871* .....

P. O. Address *7814 S. Broad* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.