

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021566

STATE FILE NUMBER

FILED JUL 13 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3148

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Maryville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE Doctors Hospital		Length of stay in lb 3 days	d. STREET ADDRESS 703 East 7th
3. NAME OF DECEASED (Type or print) First Darlene Middle B Last Mitchell		4. DATE OF DEATH Month June Day 27 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1929
9. AGE (In years local time) 29		10. USUAL OCCUPATION (Give kind of work done during life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Nodaway County Mo
13a. FATHER'S NAME Darl Porter		13b. MOTHER'S MAIDEN NAME Helen Claycomb	14. NAME OF HUSBAND OR WIFE Paul Mitchell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, Not known) (If yes, give No dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Paul Mitchell Address Maryville, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 4 hrs 8 Mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Leukemia DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) 2044			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 _____ 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 Apr 26 1959 and last saw her alive on June 26, 1959 Death occurred at 4:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F.W. Thompson D.O.		22b. ADDRESS 705 Bryant Bldg	
22c. DATE SIGNED 6-27-59		22d. LOCATION (City, town, or county) (State) Maryville Mo.	
23a. BURIAL, CREMATION, or other disposition Removal		23b. DATE 6-27-59	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 6-27-59	
ADDRESS K. C. Mo.		26. REGISTRAR'S SIGNATURE neva minshall	

F. W. Thompson, Jr. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. 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 *Joe B. Yoder*

Licensed Embalmer No. ~~41~~ *41*

P. O. Address *K.C. 7m*

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.