

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021304

FILED VS JUN 15 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5567** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY L		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis (9)	Length of stay in lb 48 yrs	c. CITY OR TOWN St. Louis (9)	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5400 Arsenal St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) May Mitchell	First May Middle Mitchell Last Mitchell	4. DATE OF DEATH May 27th 1960
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/28/84	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months 7 Days 10	IF UNDER 24 HR Hours 10 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (City and state or country) Canada	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Michael Mitchell	13b. MOTHER'S MAIDEN NAME Mary Hayes	14. NAME OF HUSBAND OR WIFE None
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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) No	16. SOCIAL SECURITY NO. Nine	17. INFORMANT Address Rita Glackin 5524 Natural Bridge Ave (20)
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute pulmonary embolism, bilateral Thrombosis of left femoral and common iliac veins.		
CONDITION (If any, which gave rise to cause (a), stating the underlying cause last.)	DUE TO (b)	
	DUE TO (c) 904.7	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Recent and old fracture of femurs.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) Fell at State Hospital
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20c. TIME OF INJURY 12-1958 and 4-1960	Hour 12-1958 s.m. 4-1960 p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 13 Hospital	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri. COUNTY STATE
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21. I attended the deceased from **March 7, 1912** to **May 27, 1960** and last saw her/him alive on **May 27, 1960**
 Death occurred at **2:00 Pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. Hopfalter M.D. (Degree or title)	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 5/28/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 31, 1960	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) Affton (23) Mo.
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24. FUNERAL DIRECTOR Fondler Und. Co. 7420 Michigan Ave. (11)	25. DATE RECD. BY LOCAL REG. MAY 31 1960	26. REGISTRAR'S SIGNATURE Ronald Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

71 82

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. G. Petersen

Licensed Embalmer No. 3767

P. O. Address 7420 Mi

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.