

**REGISTRATION DISTRICT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-041307**

FILED 13 DEC 13 1960

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 2011 Registrar's No. 110

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Carroll</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Saline</u>
Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Marshall</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hosp.</u>		d. STREET ADDRESS <u>223 E Yerby</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)	First <u>PAULELA</u>	Middle <u>ELLEN</u>	Last <u>MITCHELL</u>	<b>4. DATE OF DEATH</b> Month <u>December</u>	Day <u>7</u>	Year <u>1960</u>
---	-------------------------	------------------------	-------------------------	---	-----------------	---------------------

<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-6-1960</u>	<b>9. AGE (last birthday)</b>	<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	<b>IF UNDER 24 HR</b> Hours <u>1</u> Min.
--------------------------------	---	---	---	-------------------------------	---	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>XXXXXX</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>X XXXX</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Carrollton Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
---	---	--	--

<b>13a. FATHER'S NAME</b> <u>Clyde Mitchell</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Doris Foote Mitchell</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>XXXXXX</u>
--	---	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>XX</u> <u>XX</u>	<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> <u>Clyde Mitchell</u>	<b>Address</b> <u>223 E Yerby Marshall</u>
---	---	---	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____	
DUE TO (c) _____	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
--	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____
--

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Carrollton, Mo.</u>	<b>COUNTY</b> <u>Carroll</u>	<b>STATE</b> <u>Mo.</u>
--	---	---	---------------------------------	----------------------------

**21. I attended the deceased from** 12-6-60 **to** 12-7-60 **and last saw** him **alive on** 12-7-60  
**Death occurred at** 5:15 **p** m **on the date stated above, and to the best of my knowledge, from the causes stated.**

<b>22a. SIGNATURE</b> <i>[Signature]</i>	<b>22b. ADDRESS</b> <u>Carrollton, Mo.</u>	<b>22c. DATE SIGNED</b> <u>12-7-60</u>
---	---	---

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>12-8-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>HedgePark Cemetery</u>	<b>23d. LOCATION (City, town, or county)</b> <u>Marshall, Missouri</u>	<b>(State)</b> <u>Mo.</u>
---	--------------------------------------	--	---	------------------------------

<b>24. FUNERAL DIRECTOR</b> <u>Jack W. Keser</u>	<b>ADDRESS</b> <u>Marshall, Mo</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-8-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>
---	---------------------------------------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

02-7-11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jack M. Lisen

Licensed Embalmer No. 4643

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.