

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046956

FILED VS JAN 3 1961 *ep*

Registration District No. 201 Primary Registration District No. \_\_\_\_\_ Registrar's No. 281 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clearmont</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>Fairfax</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Waldon Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DENNIS</u> Middle <u>GROVER</u> Last <u>MITCHELL</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1960</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>11</u> Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	11. BIRTHPLACE (City and state or country) <u>Tarkio, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S</u>
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13a. FATHER'S NAME <u>Anthony Mitchell</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Frances Menifee</u>	14. NAME OF HUSBAND OR WIFE <u>Rosa Frances Mitchell</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>284-40 9873</u>	17. INFORMANT <u>Glenn Mitchell</u> Address <u>Fairfax, Mo.</u>
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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) <u>Medullary Paralysis. (Inc. intracranial Press.)</u>		<u>8 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Thrombotic Encephalomalacia with probable cerebral hemorrhage, basilar portion.</u>	<u>8 hours.</u>
	DUE TO (c) <u>Arteriosclerosis.</u>	<u>years.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility, inanation, malnutrition, prolonged recumbency.</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from Dec. 18, 1960 to Dec. 19, 1960 and last saw <sup>him</sup> alive on Dec. 18, 1960  
Death occurred at 8:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Elmo, Mo.</u>	22c. DATE SIGNED <u>Dec, 20, 60.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>12/21/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Home Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Tarkio, Mo.</u>
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24. FUNERAL DIRECTOR <u>Davis Funeral Home</u> ADDRESS <u>Tarkio, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-24 60</u>	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Frost A. Brown

Licensed Embalmer No. 3338

P. O. Address Tarkio, Mo.

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