

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037851

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9252

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED SEP 27 1963

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS, MO.**
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ST. LOUIS CITY HOSP. # I**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY
c. CITY OR TOWN **St. Louis**
d. STREET ADDRESS (If outside, give location) **1841 S. 9th**

3. NAME OF DECEASED (Type or print) First Middle Last
FRANK W. MITCHELL

4. DATE OF DEATH Month Day Year
9 14 63

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **8/1/02** 9. AGE (last birthday) **61**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Grinder** 10b. KIND OF BUSINESS OR INDUSTRY **Brass Work** 11. BIRTHPLACE (City and state or country) **Missouri** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Ervin Mitchell** 13b. MOTHER'S MAIDEN NAME **Mamie Foster** 14. NAME OF HUSBAND OR WIFE **Gracie**

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. 17. INFORMANT Address **Gracie Mitchell, 1841 S. 9th**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Right middle cerebral artery thrombosis**
Conditions of any which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Cerebral arteriosclerosis**
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Senile Emphysema**
PART III. If deceased was female was there a pregnancy in last 90 days. **332x**

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **9/11/63** to **9/14/63** and last saw her alive on **9/11/63**
Death occurred at **11:20 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Robert P. Phillips M.D.** 22b. ADDRESS **1515 LAFAYETTE AVE.** 22c. DATE SIGNED **9/14/63**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **9/18/63** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Lebanon Cem.** 23d. LOCATION (City, town, or county) (State) **St. Louis Co., Mo.**

24. FUNERAL DIRECTOR ADDRESS **McLAUGHLIN'S, 2301 Lafayette** 25. STATE REG. BY LOCAL REG. **SEP 16 1963** 26. REGISTRAR'S SIGNATURE **Robert P. Phillips M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

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 _____ Signed H. G. Jarvis

Signature of Student Embalmer

Licensed Embalmer No. 3384

P. O. Address H. Jarvis

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.