

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

00125 300

1. PLACE OF DEATH *Clay*
County *Clay* Registration District No. *197*
Township *Excelsior* Primary Registration District No. *5276* File No. *26766*
City _____ Registered No. *43*
St. _____ Ward _____

2. FULL NAME *Peter Fitzgerald*
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *48* yrs. *11* mos. *8* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 18 1848*
7. AGE YEARS *78* MONTHS *6* DAYS *22*
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED *Farmer*
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Clay Co. Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Valentine Fitzgerald*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Elizabeth Gosh*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)

14. INFORMANT *Elizabeth Fitzgerald*
(Address) *Parsons, Mo. 64658*

15. FILED *10-12-27* REGISTRAR *JR Wa 94*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 27 1927*
17. I HEREBY CERTIFY, That I attended deceased from *June 1* 19 *27* to *Sept 27* 19 *27*
that I last saw him alive on *Sept 23* 19 *27*, and that death occurred, on the date stated above, at *12 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Squale arterial Sclerosis
cardiac weakness.
97 (duration) / yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *97B*
(duration) / yrs. mos. ds.

18. WHERE WAS DISEASE MONITORED? _____
IF NOT IN PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) *J. Anderson*, M. D.
, 19 (Address) *Parkville*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *German Cem* DATE OF BURIAL *9-29-27*

20. UNDERTAKER *Harry J. Howard* ADDRESS *Parkville*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

