

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson
Township 1st
City Kansas City (No. 1002)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1103
Ward 1-3

2. FULL NAME

Fitzpatrick, James
(a) Residence, No. 73rd + Wyoming St Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9, 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 | 00 | 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) MO

PARENTS

10. NAME OF FATHER John Fitzpatrick

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Bridget Flood

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

14. INFORMANT Recrd Clerk (Address) K.C. General Hosp

15. FILED May 15 1928 M. M. Browne REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-14 1928

17. I HEREBY CERTIFY That I attended deceased from 5-8 1928 to 5-14 1928 that I last saw him alive on 5-14 1928, and that death occurred, on the date stated above, at 2:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic cerebro spinal meningitis

CONTRIBUTORY (SECONDARY) 24 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Cen. Lab Findings
(Signed) P. E. Williams, M. D.

5-14, 1928 (Address) Subt K.C. Gen. Hosp.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. St. Mary Cem DATE OF BURIAL May 16 1928

20. UNDERTAKER A. P. Doehler ADDRESS 1415 E 15

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

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