

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

Do not use this space.

4 3729

**1. PLACE OF DEATH**

County Shelby Registration District No. 830  
 Township East River Primary Registration District No. 6091  
 City Shelbyville Mo (No. ....) St. .... Ward .....

File No. ....  
 Registered No. ....

**2. FULL NAME**

Mathurie Jean Fitzpatrick

(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-13 1930

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

17. I HEREBY CERTIFY, That I attended deceased from 2-1-29 1929 to 1-12-30 1930 that I last saw her alive on 1-12- 1929, and that death occurred, on the date stated above, at 9 9 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 17. 1845

THE CAUSE OF DEATH WAS AS FOLLOWS

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>84</u>	<u>4</u>	<u>12</u>	<u>-</u>

Septic Gall Bladder

127B

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Keeper  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

(duration) yrs. 3 mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Monroe Co. Mo.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

**10. NAME OF FATHER**

J. Harrison

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no.

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) A. M. Wood, M. D.

**12. MAIDEN NAME OF MOTHER**

Mary Jane Smith

2-14-1930 (Address) Shelby

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

\*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.

**14. INFORMANT**

Chas. J. Massie  
 (Address) Shelby Mo.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

DATE OF BURIAL

J.O.O.F. Shelby Mo. Jan. 15 1930

**15. FILE NO.**

1930 Madgepool

**20. UNDERTAKER**

ADDRESS

J.B. Brothers Shelby Mo.

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.

20 1930

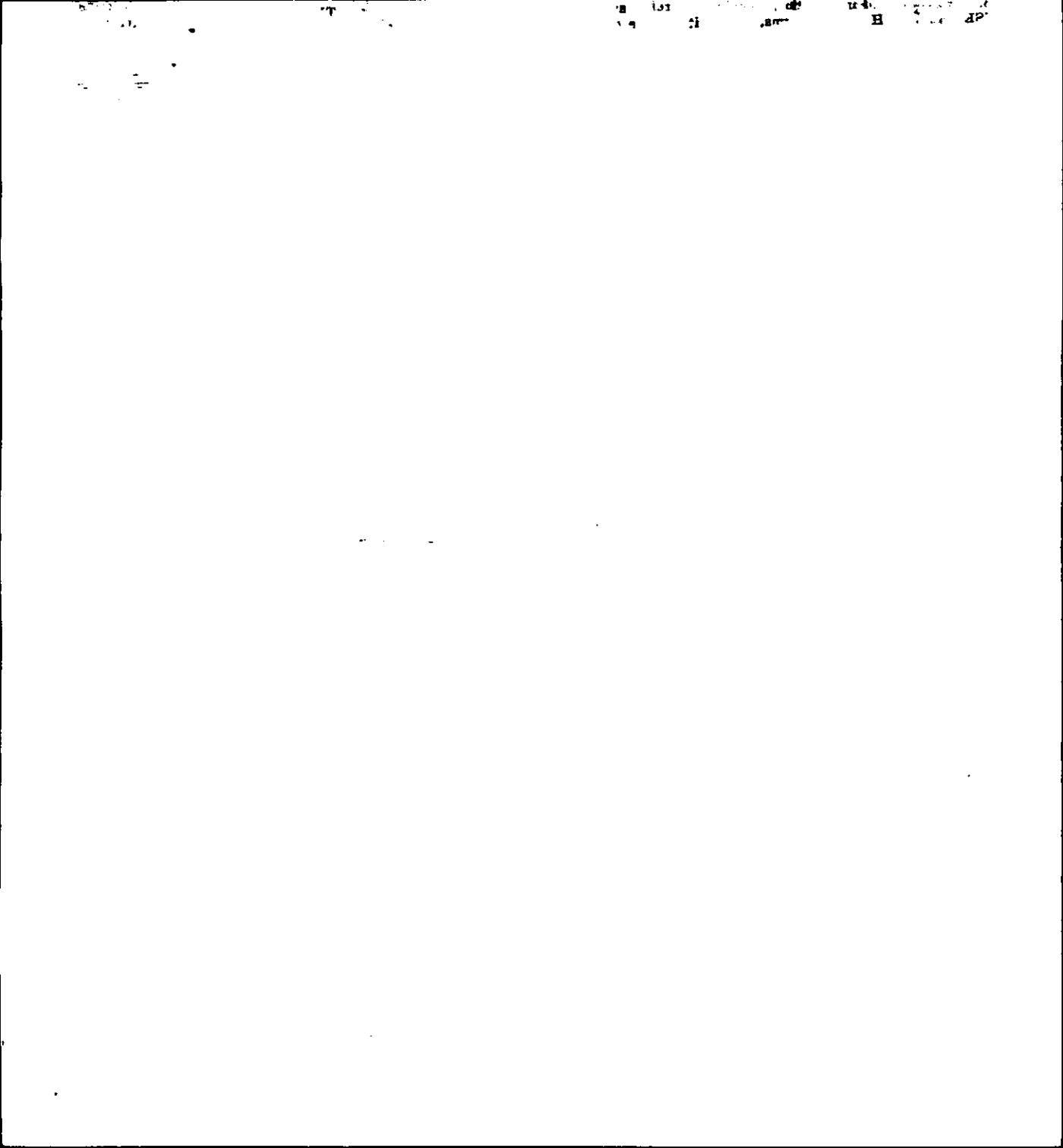
23

1

2

REGISTRAR

Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Shelby Registration District No. 830 File No. \_\_\_\_\_  
 Township salt river Primary Registration District No. 6091 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Katherine Jane Fitzpatrick  
 (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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** wid  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. ds.  
 (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)**

**10. NAME OF FATHER**

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

**12. MAIDEN NAME OF MOTHER**

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

**14. PARENTS**

INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

**15. FILED** Feb 10 30 Madge Good REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 13 1930

**17. I HEREBY CERTIFY**, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw h. \_\_\_\_\_ since o. \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septic Bact. Bladder  
Heart know.  
 \_\_\_\_\_ (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)** 124 W  
 \_\_\_\_\_ (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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** DATE OF BURIAL \_\_\_\_\_

**20. UNDERTAKER** ADDRESS \_\_\_\_\_

N. B. - In case of information not readily supplied, AGE should be stated. EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED.

S-3729