

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

AR 25 1930

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

Do not use this space.

4324

File No.
 Registered No. 7
 St. Ward)

1. PLACE OF DEATH

County Carroll Registration District No. 138
 Township Fairfield Primary Registration District No. 5202
 City Waverly (No. St. Ward)

2. FULL NAME Selen Miffen Fitzwater

(a) Residence. No. St. Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. X mos. X ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22-1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 11 24

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (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) Va

10. NAME OF FATHER Wm Fitzwater

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

12. MAIDEN NAME OF MOTHER Leont Benin

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

14. INFORMANT Miss Alice Fitzwater
 (Address) Dorson Mrs

15. Feb 20, 1930 E. H. Missourick
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18, 1930

17. I HEREBY CERTIFY, That I attended deceased on Feb 15, 1930 to one year only that I last saw h. alive on Feb 15, 1930, and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: -

General Peritonitis
due to rupture of indurated liver
of tuberculous origin
 (duration) yrs. mos. 2 ds.

CONTRIBUTORY Carcinoma of Testis
 (SECONDARY)
 (duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED to my knowledge -

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

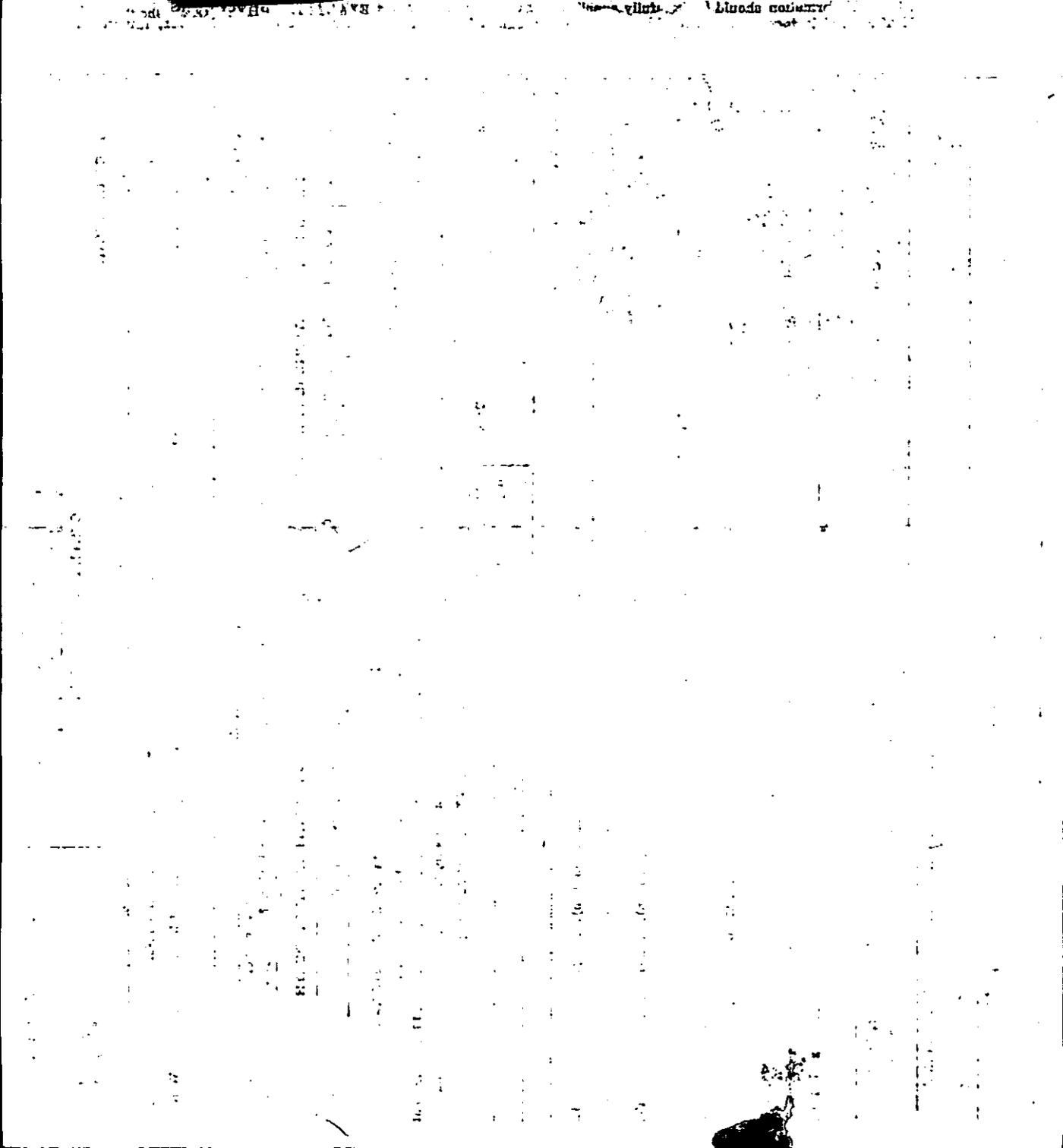
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) E. L. Woosley, M. D.

Feb 17, 1930 (Address) Braymer, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Aliver Cem DATE OF BURIAL 2/18/30

20. UNDERTAKER B F Mead ADDRESS Braymer



**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 Carroll
Township Fairfield
City Paris (No., Ward)

Registration District No. 138
Primary Registration District No. 3202

File No.
Registered No. 7
St. Ward)

2. FULL NAME Solomon Miffness Fitzwater

(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 M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 - 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than I day, hrs. or min.
<u>72</u>	<u>X</u>	<u>11</u>	<u>24</u>	

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. INFORMANT (Address)

15. April 10, 1936 E. H. Mason REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 / 16 1936

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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

19

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so 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 BY LAW

SUPPLEMENTARY

S-4324