

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

Do not use this space.

6512

1. PLACE OF DEATH

County.....

Registration District No.....

701
1002

Township.....

Primary Registration District No.....

City St. Louis

(No. 2857 N. Grand)

File No.....

Registered No.....

1327

St.....

Ward.....

2. FULL NAME

Julia Fitzpatrick

(a) Residence No. 2857 N. Grand St. 10 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

Female

4. COLOR OR RACE

White

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

married

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

Thomas Fitzpatrick

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

Dec 21, 1863

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs.

or min.

66

1

16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Asst. Surgeon

(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)

New York

10. NAME OF FATHER

Ferdinand Kaiser

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14. INFORMANT

(Address)

Thomas Fitzpatrick
2857 N. Grand

15. FILED

....., 19.....

Max C. Storking
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb 7 1930

17.

I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1930, to Feb 7, 1930.

that I last saw her alive on Feb 7, 1930, and that death occurred, on the date stated above, at 1:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108
1930
1327
Acute Maxillary Bronchitis
to Lobar Pneumonia (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY)

Left Lobar Pneumonia 12 days
Chronic Myocarditis 2 years (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?

Physic. findigs & cultures

(Signed)

Geo. Storking, M. D.

2/7, 1930 (Address)

3442 Geraldine Ave

*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

Calvary

Feb 10 1930

20. UNDERTAKER

ADDRESS

Ashton L & Co 2707 N. Grand

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.

7330
2
10
31

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

