

OCT 20 1937

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

Do not use this space.

## 1. PLACE OF DEATH

 County FRANKLIN  
 Township  
 City Gerald (No. 2)

 Registration District No. 1104  
 Primary Registration District No. 4554

 File No. 34178  
 Registered No. 11  
 St. \_\_\_\_\_ Ward \_\_\_\_\_
2. FULL NAME Dr. Wm. P. Fitzgerald
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

 Length of residence in city or town where death occurred 76 yrs. — 22 mos. 22 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

## MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lizzie E. Fitzgerald</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 23, 1861</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>--</u>	DAYS <u>22</u>
		If LESS than 1 day, _____ hrs. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 14, 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 8:15 P. M.

The principal cause of death and related causes of importance were as follows:

Automobile Accident. Broken left arm at wrist. Broken right collar bone & crushed chest. Wound L. temple, possible concussion. Skin abrasions of chin & Scalp wounds.

Other contributory causes of importance: Hypostatic Pneumonia

Deceased was driving this own automobile at time of accident

Name of operation None Date of \_\_\_\_\_What test confirmed diagnosis? Physical Was there an autopsy? No23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 9/11, 1937Where did injury occur? Canaan Township, Gasconade Co. (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place. Public PlaceManner of injury AccidentalNature of injury Automobile Accident24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify \_\_\_\_\_

(Signed) Thos. P. Sheffer M. D.(Address) Coroner, Sullivan, Mo.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Physician and Surgeon</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year) <u>Sept. 11, 1937</u>
	11. Total time (years) spent in this occupation <u>50 yrs</u>

12. BIRTHPLACE (CITY OR TOWN) Gerald, Mo. (STATE OR COUNTRY)13. NAME Squire, Fitzgerald14. BIRTHPLACE (CITY OR TOWN) St. Louis County, Mo. (STATE OR COUNTRY)15. MAIDEN NAME Eliza Jane Wiseman16. BIRTHPLACE (CITY OR TOWN) St. Louis Co., Mo. (STATE OR COUNTRY)17. INFORMANT Thos. A. Fitzgerald (ADDRESS) Annapolis, Md.18. BURIAL, CREMATION, OR REMOVAL PLACE Boeuf Cem. Gerald DATE 9-16 3719. UNDERTAKER G. Meyer (ADDRESS) Gerald20. FILED 9-15 19. 37 Charles P. de Ne... Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

34178  
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 1104  
(b) Township Gerald Primary Registration District No. 4554 Registered No. \_\_\_\_\_  
(c) City Gerald (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dr. Wm P. Fitzgerald

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 - 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 14 1937

22. I HEREBY CERTIFY, That I attended deceased from 1937 to \_\_\_\_\_, 1937

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1937. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

automobile accident  
Deceased was driving his own automobile at the time of accident, on Highway 50 in Gasconade Co., on September 11.

Other contributing causes of death were \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1937

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Thos P. Shaffer M. D.

(Address) Coroner Sullivan Co

REGISTRARS SHALL NOT RECEIVE A FEE, FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-34178