

DECEMBER 6 1939

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

2201
Do not use this space.

1. PLACE OF DEATH

(a) County FRANKLIN Registration District No. 295
(b) Township MERAMEC Primary Registration District No. 4179 Registered No. _____
(c) City SULLIVAN (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 32 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JAMES WILLIAM FITZPATRICK

(a) Residence, No. SULLIVAN, MISSOURI. 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 13, 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 2 8

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. Justice of Peace
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 7

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

FATHER 13. NAME Philip Fitzpatrick

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

MOTHER 15. MAIDEN NAME Priscilla Allen

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

17. INFORMANT (ADDRESS) Anna Fitzpatrick Sullivan, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sullivan, Mo DATE Jan. 23, 1939

19. FUNERAL DIRECTOR (ADDRESS) Thos. P. Shaffer Sullivan Missouri

20. FILED Jan 25 1939 Calvin W. Stapp Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 21, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1939, to January 21, 1939
Last saw him alive on Jan. 21, 1939 Death is said to have occurred on the date stated above, at 11:55 A. M.

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

Acute cardiac dilatation

Other contributory causes of importance Cold & influenza

Name of operation None Date of _____
What test confirmed diagnosis? Physical Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
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? NO.
If so, specify _____
(Signed) R. P. [Signature], M. D.
Sullivan, Missouri.

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.

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STATEMENT BY LICENSED EMBALMER

I, Edgar W. Taffoo, Licensed Embalmer No. 3394

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. 3394 or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed Edgar W. Taffoo

Licensed Embalmer No. 3394

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

EMERALD STATEMENT

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Franklin Registration District No. 296
(b) Township Sullivan Primary Registration District No. 4179 Registered No. _____
(c) City Sullivan (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 James William Fitzpatrick
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-21-1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 2 8

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

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 _____

acute Cardiac Dilatation 9371 Date of onset _____

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

Other contributory causes of importance:

13. NAME

Myocarditis

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

Name of operation _____ Date of _____

15. MAIDEN NAME

What test confirmed diagnosis? _____ Was there an autopsy? _____

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

17. INFORMANT (ADDRESS)

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury _____
Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED _____, 19____

If so, specify _____ (Signed) R. P. Proyer, M. D.
(Address) Sullivan Mo

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. -
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-2201