

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

9904
Do not use this space.

APR 24 1939

1. PLACE OF DEATH

(a) County Wendover Registration District No. 26
 (b) Township West Kewa Primary Registration District No. 3002 Registered No. 47
 (c) City Mexico Mo. (d) Street No. Andraus Hospital 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

(a) Residence, No. 39.1 Cuthis Fitzpatrick Jr. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-27-39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
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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) Mexico Mo.

FATHER 13. NAME Cuthis Marion Fitzpatrick

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

MOTHER 15. MAIDEN NAME Alba Bell Hill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New London Iowa

17. INFORMANT (ADDRESS) Father Vandavia Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Chapel Co DATE 3/29/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) None Taken

20. FILED 3-28-39 B. Keith Keely Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28-1939

22. I HEREBY CERTIFY, That I attended deceased from 3-27-1939 to 3-28-1939

I last saw him alive on 3-28-1939 Death is said to have occurred on the date stated above, at 4:30 p.m.

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

Premature Birth
159

Other contributory causes of importance:
Mother had pneumonia

Name of operation None Date of _____
 What test confirmed diagnosis Clinical 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) W. T. McCall M. D.
Laddonia

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

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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RECEIVED

District Health Officer No: 10

District File Number 10-39-528

Date Filed APR 20 1939

10 ST 1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.