

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 301217
Registrar's No. 36

REC'D SEP 13 1939

Registration District No. 1939

Primary Registration District No. 4466

1. PLACE OF DEATH:

(a) County Ste Genevieve 3
(b) City or town Ste Genevieve
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 5
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME ACE I F. FITZKAM 325

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased August 15 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>10</u>	_____ hr. _____ min.

9. Birthplace Ste Genevieve Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Olive Fitzkam

13. Birthplace Ste Genevieve Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Purdie

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Olive Fitzkam

(b) Address Ste Genevieve MO

17. (a) Burial (b) Date thereof Aug 25 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste Genevieve Mo

18. (a) Signature of funeral director James H. Shuman

(b) Address Ste Genevieve Missouri

19. (a) Aug. 25/39 (b) T. W. Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 25 day 25th
year 1939 hour 8:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from Aug 15
1939 to Aug 25 1939
that I last saw him alive on Aug 24 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 8-24-39

Due to UNKNOWN

Due to UNKNOWN

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Arthur E. Shuman (M. D. or other) m

Address Ste Genevieve MO Date signed 8-25-39

PHYSICIAN
Underline the cause to which death should be charged statistically

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

1092

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 complete the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30121

Do not use this space.

1. PLACE OF DEATH

(a) County St. Genevieve Registration District No. 181
(b) Township St. Genevieve Primary Registration District No. 4466 Registered No. 36
(c) City..... (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 Accl F Fitzkeam

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8 (write the word)

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. 10

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

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

MOTHER 15. MAIDEN NAME

MOTHER 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) 8-25-39 1939

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

I last saw h..... alive on....., 19..... 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:

Pneumonia
bronchial
N.M.D.
Date of onset 8-25-39

Other contributory causes of importance: 1074

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....., 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?.....

If so, specify

(Signed) Arthur S. Searles, M. D.

(Address) St. Genevieve Mo

DEPARTMENT OF HEALTH
AND HUMAN SERVICES
NATIONAL CENTER FOR VITAL STATISTICS

STATE OF DEATH

19 81

NAME OF DECEASED: JEFFREY I. ...

DATE OF DEATH: ...

PLACE OF DEATH: ...

CAUSE OF DEATH: ...

ICD-9 CODE: ...