

No. 2  
-11-10-39  
5-17-39  
P1 X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13783

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1495

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
5334 Tracy Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 42 Yrs.  
years, months or days) \_\_\_\_\_

8. (a) PRINT FULL NAME Catherine G. FITZSIMONS.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John Fitzsimons 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 14th, 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 9 19 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Burlington Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name William Manson

13. Birthplace Unknown

14. Maiden name Quintilean Kinzie

15. Birthplace Unknown

16. (a) Informant G. Kinzie Fitzsimons.

(b) Address 5334 Tracy Ave.

17. (a) Burial (b) Date thereof 4/6/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery.

18. (a) Signature of funeral director Melody-McGillev.

(b) Address K. C. Mo.

19. (a) April 6, 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5334 Tracy Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd  
year 1940 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1935  
\_\_\_\_\_, 19\_\_\_\_ to 4/3/40, 19\_\_\_\_;  
that I last saw her alive on 4/3/40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 30 min

Due to Chronic Hypertension 15 yrs.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: no  
Of operations \_\_\_\_\_

Of autopsy no

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) \_\_\_\_\_  
(a) \_\_\_\_\_ of injury !

23. Signature [Signature] (M. D. certificate) 9/10  
Address 1103 Grand Date signed 4/6/40

Dr. Webster  
Argyle Bldg.

**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. 2999

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.**