

FILED MAR 1 1942

LOCAL REGISTRAR'S RECORD - DO NOT TEAR LEAF

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

7319

Registration District No. 582

Primary Registration District No. 578-35774 Registrar's No. 8

1. PLACE OF DEATH

(a) County Monroe
 (b) City or town Santa Fe Mo
 (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

3 (a) PRINT FULL NAME MICHAEL FITZPATRICK

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced W6. (b) Name of husband or wife Minnie Fitzpatrick 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased April 15 1864
(Month) (Day) (Year)8. AGE: Years 77 Months 10 Days 27 If less than one day _____ hr. _____ min.9. Birthplace Monroe Mo
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Patrick Fitzpatrick13. Birthplace Ireland
(City, town, or county) (State or foreign country)14. Maiden name Bridget Hills15. Birthplace Ireland
(City, town, or county) (State or foreign country)6. (a) Informant Minnie Fitzpatrick (Wife)(b) Address Santa Fe Mo7. (a) (Burial, cremation, or removal) _____ (b) Date there Feb 17 1942
(Month) (Day) (Year)(c) Place: burial or cremation Indian Creek8. (a) Signature of funeral director Snyder & Franz(b) Address Santa Fe Mo9. (a) Feb 19 1942 (Date received local registrar) W. E. Reason (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Monroe
 (c) City or town Santa Fe
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15th
year 1942 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from Feb - 1
15, 1942, to Feb 15, 1942
that I last saw him alive on Feb 15, 1942
and that death occurred on the date and hour stated above.Immediate cause of death hypertensive chronic
arteriosclerosis Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1318

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 John Perry (M. D. or other) _____Address Perry, Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

1168

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH

- (a) County _____
 (b) City or town _____
(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)

3 (a) PRINT FULL NAME

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

- | | | |
|--------------|------------------------|---|
| 4. Sex _____ | 5. Color or race _____ | 6. (a) Single, widowed, married, divorced _____ |
|--------------|------------------------|---|

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

7. Birth date of deceased _____
(Month) (Day) (Year)

- | | | | |
|---------------|--------|-------|----------------------|
| 8. AGE: Years | Months | Days | If less than one day |
| _____ | _____ | _____ | _____ hr. _____ min. |

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

10. Usual occupation _____

11. Industry or business _____

- | | | | |
|---------------|---|-----------------------|---|
| MOTHER FATHER | { | 12. Name _____ | 13. Birthplace _____
<small>(City, town, or county) (State or foreign country)</small> |
| | { | 14. Maiden name _____ | 15. Birthplace _____
<small>(City, town, or county) (State or foreign country)</small> |

16. (a) Informant _____
 (b) Address _____

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

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____

that I last saw him _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

RECEIVED

Due to **District Health Officer No. 10**
 District File Number 10-42-337
 Date Filed **MAR 10 1942**

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

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underlie the cause 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 _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____