

FILED NOV 22 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Firmin Desloge**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **William F. Fitzgerald**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Catherine** 6. (c) Age of husband or wife if alive **55 1/2** years

7. Birth date of deceased **Jan 29th, 1889**
(Month) (Day) (Year)

8. AGE: Years **75** Months **10** Days **12** If less than one day hr. min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Plumber**

11. Industry or business **Owner**

12. Name **Thomas A Fitzgerald**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Johanna O'Connor**

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

16. (a) Informant **Mrs. Catherine Fitzgerald**

(b) Address **3127 Locust St.**

17. (a) **Burial** (b) Date thereof **11/14/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cent.**

18. (a) Sign **Harrison & Sheehan Und Co**

(b) Address **4415 Washington Blvd**

19. (a) (Date received local registrar) (b) (Registrar's signature) **J. J. [Signature]**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3127 Locust St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11-11-44** day
year **11-11-44** hour **6:48 p.m.** minute M.

21. I hereby certify that I attended the deceased from **10-30-44**, 19, to **11-11-44**, 19;
that I last saw him alive on **11-11-44**, 19,
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cholecystitis**
Acute CholeCystITIS

Duration **6 days**

Due to **Chronic cholecystitis - non calculous**
Peritonitis - abdominal - exudation
Due to **Secondary bacteremia**

Other conditions **a**
(Include pregnancy within 3 months of death)

Major findings: **127**
Of operations
Of autopsy

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

22. If death was due to external causes, fill in the following:
(c) 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 **Roscoe P. Kearney** (M. D. or other)
Address **Firmin Desloge Hospital** Date signed **11-13-44**

NOV 13 1944

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: Gray W. Wilkins

Licensed Embalmer No. 3575

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, fact should be so stated above.