

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 30 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 205

Registration District No. 128 Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
SPRINGFIELD CITY HOSP.
(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 MO. (b) County GREENE
(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 2306 East Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME JAMES FITCH.
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 NORA FITCH 6. (c) Age of husband or wife if alive UNK.
7. Birth date of deceased Oct. 10, 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 2
If less than one day
.....hr.min.

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

10. Usual occupation Laborer (Retired)

11. Industry or business.....

MOTHER, FATHER
12. Name George Fitch
13. Birthplace UNK. Unknown
(City, town, or county) (State or foreign country)
14. Maiden name UNK. Unknown
15. Birthplace UNK. Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Wade Storn

(b) Address SPRINGFIELD MO.

17. (a) Burial (b) Date thereof Mar 15-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. Klingner & Co

18. (a) Signature of funeral director W. Klingner
(b) Address SPRINGFIELD MO.

19. (a) 3-14-45 (b) W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12
year 1945 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from 3-8, 1945, to 3-12, 1945;
that I last saw him alive on 3-11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death) 108

Major findings:
Of operations.....
Of autopsy.....

Duration 5 days

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? Yes (Specify type of place) (c) Means of injury Car

23. Signature W. Handley (M: D. or other) M.D.
Address Springfield Mo Date signed 3-14-45

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.....

Max Rhodes

Licensed Embalmer No.....

4071

P. O. Address.....

Springfield

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.

X