

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

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 29 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27191**  
Registrar's No. **72**

Registration District No. **93**

Primary Registration District No. **4103**

1. PLACE OF DEATH:

(a) County **Dade**  
(b) City or town **Lockwood**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Lockwood Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 days**  
(Specify whether years, months or days)  
In this community **25 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper 49**  
(c) City or town **Golden City Rural 3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5 Mi. SE Golden City 1**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **EVA NORA FITCHPATRICK**

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

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

6. (b) Name of husband or wife **J.T. Fitchpatrick** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **September 1865**  
(Month) (Day) (Year)

8. AGE: Years **81** Months **10** Days **22**  
If less than one day hr. min.

9. Birthplace **Logan County Ky. 1**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name **James Barker**  
13. Birthplace **Ky. 1**  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Earl Fitchpatrick**  
(b) Address **Golden City, Mo.**

17. (a) **burial** (b) Date thereof **Aug. 17, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **I.O.O.F. Cem. Golden City, Mo.**

18. (a) Signature of funeral director **Phillips Funeral Home**  
(b) Address **Golden City, Mo.**

19. (a) **Aug. 14-47** (b) **Ed R. Wells**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **15**  
year **1947** hour **3** minute **30** M.

21. I hereby certify that I attended the deceased from **August 12** 19**47** to **Aug 15** 19**47**  
that I last saw her alive on **Aug 15** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiovascular, acute**

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

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

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy **120A**

Duration \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature **Jack H. Bixner** (M. D. number) \_\_\_\_\_  
Address **Lockwood, Mo.** Date signed **Aug 15-47**

RECEIVED

District Health Officer No. 6,

District File Number 847-915-

Date Filed AUG 27 1947

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 J. P. Beugh

Licensed Embalmer No. 3278

P. O. Address Golden City, Mo.

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.

Registration District No. 93 Primary Registration District No. 4153

1. PLACE OF DEATH:  
(a) County Oade Lockwood  
(b) City or town  
(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.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Eva N. Fitchpatrick  
3. (b) If veteran, name war..... 3. (c) Social Security No.....  
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased Sept 2 (Month) 1942 (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April, year 1942, hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw h..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

8. AGE: Years 81 Months..... Days..... If less than one day hr..... min.....

Duration  
Due to.....  
Due to.....  
Other conditions..... (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

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

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) (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

**SUPPLEMENTARY**

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

27191