FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 13 1948

Registration District No. 367

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 24999

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Normandy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Normandy Osteopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DEACESED: 11877 96

(a) State: Mo. (b) County: St. Louis

(c) City or town: Wellston
(If outside city or town limits, write "RURAL")

(d) Street No.: 1827 Kienlen Ave.,
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: Mary Fitzpatrick.

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: March 4, 1858.
(Month) (Day) (Year)

8. AGE: Years: 90 Months: 5 Days: 1 If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired

11. Industry or business ____

FATHER
12. Name: Tom Fitzpatrick
13. Birthplace: Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Kate Gahan
15. Birthplace: Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Fred Mueller

(b) Address: 5216 Nottingham Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 9, 1948.
(Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Jos. W. Clark

(b) Address: 1125 Hodiamont Ave.

19. (a) 8-7-48 (Date received local registrar) (b) Paul A. Stamp M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 5
year: 1948 hour: 2:30 minute: P.M. M.

21. I hereby certify that I attended the deceased from July 31, 1948, to Aug. 5, 1948, that I last saw her alive on Aug. 5, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	2 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Bronchial Pneumonia	

Major findings:
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:

(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: Paul E. Courtney (M. D. or other) D.O.

Address: 6303 Isabella Date signed: 8-6-48

(Licensed Embalmer's Statement on Reverse Side)

Dr. Paul E. Courtney,
6303 Isabella Ave.,
Co. 3322.

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 Gustav W. Dietsch

Licensed Embalmer No. 4329

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.