

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23933**

FILED AUG 14 1950

0530

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

BIRTH NO. _____		REG. DIST. NO. <b>383</b>		PRIMARY REG. DIST. NO. <b>5655</b>		Registrar's No. <b>365</b>	
1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>			
b. CITY (If outside corporate limits, write RURAL and give town): <b>Mt. Vernon</b>		c. LENGTH OF STAY (in this place) <b>1043 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Matthews</b>		<b>0720</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri State Sanatorium</b>				d. STREET ADDRESS (If rural, give location) <b>Rt. 3</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>James</b> b. (Middle) <b>Alvin</b> c. (Last) <b>Fitzpatrick</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>August 6, 1950</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>September 2, 1929</b>		9. AGE (In years last birthday) <b>20</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Alvin Fitzpatrick</b>			13b. MOTHER'S MAIDEN NAME <b>Maudie Bell Hubbard</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ruby Ann Wilson, Record Clerk</b> <b>Mo State San., Mt. Vernon, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u></b> <b>ANTECEDENT CAUSES</b> *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b) _____</b> <b>DUE TO (c) _____</b> <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.							
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <b>about 35 months</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 27, 1947</b> , to <b>August 6, 1950</b> , that I last saw the deceased alive on <b>August 5, 1950</b> , and that death occurred at <b>1:45 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>[Signature]</b>				23b. ADDRESS <b>Mt. Vernon, Mo.</b>		23c. DATE SIGNED <b>Aug. 6, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>8-6-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Piedmont</b>		24d. LOCATION (City, town, or county) (State) <b>Mo</b>	
DATE REC'D BY LOCAL REG. <b>Aug 6, 1950</b>		REGISTRAR'S SIGNATURE <b>Caril Hendricks</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Max L. Foyett</b>		ADDRESS <b>William Lee</b>	

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED AUG 8 1950  
Dist. File 850-950  
Date Filed 8-8-50

AUG 28 1950

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Wm F Fournel

Licensed Embalmer No. 4752

P. O. Address Mt Vernon, 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.