

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 22 1952

State File No. 9940

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 1745

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmen Desloge Hospital		d. STREET ADDRESS (If rural, give location) 1434 Arlington	
3. NAME OF DECEASED a. (First) John		b. (Middle) Fitzpatrick	
c. (Last) Fitzpatrick		4. DATE OF DEATH (Month) (Day) (Year) 2-22-52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7-8-78
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Denis Fitzpatrick	
14. MOTHER'S MAIDEN NAME Sarah Megas		15. NAME OF HUSBAND OR WIFE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT'S SIGNATURE OR NAME Fr. Jas. Fitzpatrick		19. ADDRESS 2300 St. Charles Rock Rd	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION July 5, 1949		19b. MAJOR FINDINGS OF OPERATION Generalized abdominal metastases.	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 177X			
22. I hereby certify that I attended the deceased from 2-20-52, 19__, to 2-22-52, 19__, that I last saw the deceased alive on 2-22-52, 19__, and that death occurred at 8:50 P.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert W. Spanding, M.D.		23b. ADDRESS 1325 S. Grand, St. Louis 4, Mo.	
23c. DATE SIGNED Feb. 23, 1952			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/25/52	
24c. NAME OF CEMETERY OR CREMATORY St. Cecelia Cemetery		24d. LOCATION (City, town, or county) (State) Clare, Mich.	
DATE REC'D BY LOCAL REG. FEB 25 1952		REGISTRAR'S SIGNATURE Carl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Cullen & Kelly		ADDRESS 4386 Lindell	

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

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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed.....

James A. Summers

Signed.....
Student Embalmer

Licensed Embalmer No. *9142*

P. O. Address *St. Louis*

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.