

FILED FEB 4 1953

STANDARD CERTIFICATE OF DEATH

State File No. 2202

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 25

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

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1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital		d. STREET ADDRESS (If rural, give location) 716 Rock Street	
3. NAME OF DECEASED a. (First) Sarah A. Fitzgerald		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) January 23, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 10, 1875
9. AGE (In years last birthday) 77		10. MONTH (Day) (Year) 10 13	11. IF UNDER 1 YEAR Hours Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) Rula Nebraska
12. CITIZEN OF WHAT COUNTRY? U S A			
13a. FATHER'S NAME Henry Walker		13b. MOTHER'S MAIDEN NAME Marthe Jane Auxier	
14. NAME OF HUSBAND OR WIFE Cecil Fitzgerald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mr. Cecil Fitzgerald		ADDRESS Hannibal Missouri	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 2 hrs  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atherosclerosis  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		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201	
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) m.		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 7-10-10, 19, to 1-23, 1953, that I last saw the deceased alive on 1-23, 1953 and that death occurred at 1:00 P.M., from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) M.D.		23b. ADDRESS Hannibal Mo	
23c. DATE SIGNED 1-25-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/26/53	
24c. NAME OF CEMETERY OR CREMATORY Mount Olivet		24d. LOCATION (City, town, or county) (State) Hannibal Missouri	
DATE REC'D BY LOCAL REG. 1-27-53		REGISTRAR'S SIGNATURE [Signature] 189-9	
25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Hannibal Missouri	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED FEB 2 1953  
MARION CO. HEALTH DEPT.  
DATE FILED FEB 2 1953

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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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed

*John S. Ward*

Licensed Embalmer No..... 4540

P. O. Address Hannibal Missouri

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.