

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29955

FILED AUG 20 1953

State File No. ....

7040

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2149</b>	
b. CITY OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>12 yr</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5630 Chippewa St.</b>		e. STREET ADDRESS (If rural, give location) <b>14 5630 Chippewa St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b> b. (Middle) <b>W.</b> c. (Last) <b>Fitzgerald</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 16 1953</b>		
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 2</b>	8. DATE OF BIRTH <b>July 4th 1875</b>		9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City of St. Louis</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Municipal</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>

13a. FATHER'S NAME <b>Frances G. Fitzgerald</b>	13b. MOTHER'S MAIDEN NAME <b>Phoebe Bell</b>	14. NAME OF HUSBAND OR WIFE <b>dec'd</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Florence Fitzgerald</b> ADDRESS <b>5630 Chippewa</b>
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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) <b>Acute Coronary heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis advanced</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 _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>420.1</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **4/29/1907**, **1907**, to **7/16/53**, **1953**, that I last saw the deceased alive on **6/25**, **1953**, and that death occurred at **5:00 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Max Hawke M.D.</b> (Degree or title) <b>0</b>	23b. ADDRESS <b>2816 Sutton ave 4660 Maryland</b>	23c. DATE SIGNED <b>7/16/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <b>7/18/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JUL 17 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. L. Ziegenhain &amp; Sons Und.</b> ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *E. P. Kidwell*.....

Licensed Embalmer No. *3877*.....

P. O. Address *7027 Grava*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.