

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34511**

FILED OCT 9 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **2560**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY 2079	
b. CITY OR TOWN Richmond Heights		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 3-hrs.		e. STREET ADDRESS (If rural, give location) 4969 Rosalie Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Jennie b. (Middle) B. c. (Last) Fitzmaurice			4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1953
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. 2	8. DATE OF BIRTH May 5, 1896
9. AGE (In years) (Month) (Days) 57 4 25		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. to Executive Sedy. O.R.Tel.	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Frank Harrison		13b. MOTHER'S MAIDEN NAME Jennie B. Oldfield	14. NAME OF HUSBAND OR WIFE Mr. Wm. Joseph Fitzmaurice
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 497-07-1926	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
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) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Atresia DUE TO (c) Hypertension 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	
19c. 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) (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 Sept 30, 1953 , to Sept 30, 1953 , that I last saw the deceased alive on Sept 30, 1953 , and that death occurred at 2:00 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Daniel P. Deane		23b. ADDRESS 607 N. Grand Ave	23c. DATE SIGNED 10-1-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct. 3, 53	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. 10/1/53	REGISTRAR'S SIGNATURE Heather S. Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. K. Kowalski 840 Lindell Blvd.	

WRITE PLAINLY—USING UNFAADING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Francis Williamson*

Licensed Embalmer No. *3565*

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