

Health, & Welfare  
Public Health Service

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI 67314-57 45081  
**STANDARD CERTIFICATE OF DEATH**  
 STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 488

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>HANNIBAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HANNIBAL</u> 664 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>St Elizabeth</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>512 Willow</u>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>FITZGERALD</u> Last <u>FITZGERALD</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-1957</u>
9. AGE (In years last birthday) <u>2</u>		10. MONTHS <u>2</u> DAYS <u>24</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>HANNIBAL MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John W. Fitzgerald</u>	
13b. MOTHER'S MAIDEN NAME <u>HELEN Wajick</u>		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) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Fitzgerald</u>		Address <u>512 Willow</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Spinal Bacteria &amp; meningococci</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) <u>Spinal Bacteria &amp; meningococci</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>751X</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>    </u> Month <u>    </u> Day <u>    </u> Year <u>    </u> a.m. <u>    </u> p.m. <u>    </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>    </u> to <u>    </u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>    </u> Death occurred at <u>6:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Samuel B. Landon, M.D.</u>		22b. ADDRESS <u>Hannibal, Missouri</u>	
22c. DATE SIGNED <u>9/26, 1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/27/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mc Oliver Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
24. FUNERAL DIRECTOR <u>W. M. O'Donnell</u>		ADDRESS <u>Hannibal Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-17-57</u>
		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>	

RECEIVED DEC 27 1957  
MARION CO. HEALTH DEPT.  
DATE FILED DEC 27 1957

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 N M O'Donnell .....

Licensed Embalmer No. 3889 .....

P.O. Address Lanvial M .....

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.