

333 FILED VS SEP 4 1959 3074

59-331182 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 147

1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi					
b. CITY (If outside corporate limits, give TOWNSHIP only) Sikeston		Length of stay in 1b 5 Days		c. CITY OR TOWN Charleston, Mo..		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 509 S.. Center		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SARAH Middle ELLEN Last FITZPATRICK				4. DATE OF DEATH Month 8 Day 13 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/12/82	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and state or country) Miss.. Co.. Mo..		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Wm. Jackson			13b. MOTHER'S MAIDEN NAME Carrie Mahon			14. NAME OF HUSBAND OR WIFE T. M. Fitzpatrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT T. M. Fitzpatrick, Charleston, Mo			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 6 da		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____					DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio Sclerotic Heart Disease						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 _____ a.m. _____ p.m.	Month, Day, Year								
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 8/5/59 to 8/13/59 and last saw her/him alive on 8/13/59 Death occurred at 10:55 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) E. Charles Kolvenig MD				22b. ADDRESS Charleston, Mo.				22c. DATE SIGNED 8/15/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/16/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove		23d. LOCATION (City, town, or county) Charleston, Mo..				
24. FUNERAL DIRECTOR Mc Mickle, Charleston, Mo..				25. DATE RECD. BY LOCAL REG. 8-24-59		26. REGISTRAR'S SIGNATURE Mrs. Ella Hunter			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____ Student Embalmer No. _____
or by _____ Student Embalmer No. _____

working under my personal supervision.
working under my personal supervision.

Student _____
Student _____
Signature of Student Embalmer _____
Signature of Student Embalmer _____

Signed _____
Signed _____

Licensed Embalmer No. _____
Licensed Embalmer No. 4695
P. O. Address _____
P. O. Address Charleston

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).
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, the association of licensees in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.
If this body is not embalmed, fact should be so stated above.