

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-033795

STATE FILE NUMBER

FILED VS SEP 3 0 1959

Registrar **2** No. **8252**

Registration District No. _____ Primary Registration District No. _____

V. S. 300

Rev. 1-57

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securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>East St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Veterans Hospital VAH</u>			Length of stay in lb <u>1 day</u>		d. STREET ADDRESS (If outside, give location) <u>510 N. 50th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE C. FITZPATRICK</u>				4. DATE OF DEATH Month Day Year <u>9 6 1959</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>Jan. 18, 1893</u>		9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and state or country) <u>Collinsville, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Luther Fitzpatrick</u>			13b. MOTHER'S MAIDEN NAME <u>Mary B. Fairbanks</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>W. W. I</u>			16. SOCIAL SECURITY NO. <u>355-07-2086</u>		17. INFORMANT <u>Thelma Beard</u> <u>510 N. 50th St. East St. Louis, Ill.</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>Status asthmaticus</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>241 X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH		
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 Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>2:32 P. M.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joan M. Green</u> (Degree or title)			22b. ADDRESS <u>1300 Clark</u>			22c. DATE SIGNED <u>9/9/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>				
24. FUNERAL DIRECTOR'S ADDRESS <u>Collinsville, Ill.</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 8'59</u>		26. REGISTRAR'S SIGNATURE <u>Keal Smith, M.D.</u>				

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 *Not Embalmed*, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Herbert A. Kasal*

Licensed Embalmer No. *2802*

P. O. Address *Collinsville, Ill*

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.