

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041828**

FILED VS. NOV 20 1959

Primary Registration District No. \_\_\_\_\_ Registrar No. **210317**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INCARNATE WORD</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>3221-PENNSYLVANIA</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle <b>FITZGIBBON</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>8</b> Year <b>1959</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 8 1891</b>		9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>			11. BIRTHPLACE (City and state or country) <b>Mo</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>JOHN COSTA</b>				13b. MOTHER'S MAIDEN NAME <b>JANE LARRITTO</b>				13c. NAME OF HUSBAND OR WIFE <b>DANIEL FITZGIBBON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT Address <b>DANIEL FITZGIBBON PENNSYLVANIA 3221 S</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10-31-59</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiovascular disease</b>										DUE TO (c) <b>hypertension (prev)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Duchenes</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <b>442x</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <b>5-12-59</b> to <b>11-8-59</b> and last saw her alive on <b>11-8-59</b> Death occurred at <b>2 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22. SIGNATURE <b>John Flynn BMD</b> (Degree or title)						22b. ADDRESS <b>1715 St 39th St</b>			22c. DATE SIGNED <b>11-9-59</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Nov. 11 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GALVARY CEM.</b>				23d. LOCATION (City, town, or county) <b>ST. LOUIS Mo</b>		(State)			
24. FUNERAL DIRECTOR <b>Thomas Lutes 2906 Gracia</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>NOV 10 1959</b>		26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-4 Francisco

PK 1-1-013

**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 *Robert C. Will*

Licensed Embalmer No. 4347

P. O. Address 2906 [unclear]

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.