

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007826

FILED VS FEB 24 1960

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 63

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON		c. CITY OR TOWN FARMINGTON	
Length of stay in 1b 25yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
CHARLES SAMUEL FITZ			FEB. 13 1960		

5. SEX MALE	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 9-10-1887	9. AGE (last birthday) 72	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)	10b. KIND OF BUSINESS OR INDUSTRY AUTO AGENCY	11. BIRTHPLACE (City and state or country) DES ARC MO	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME THOMAS P FITZ	13b. MOTHER'S MAIDEN NAME ALICE WRAST	14. NAME OF HUSBAND OR WIFE LUCY FITZ
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W W I	16. SOCIAL SECURITY NO. 493-36-6899	17. INFORMANT TOM FITZ FARMINGTON MO
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 20 min
IMMEDIATE CAUSE (a) Coronary Thrombosis		
DUE TO (b) Atherosclerosis		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 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 1955 to Feb 13/60 and last saw him alive on Feb. 13, 1960
Death occurred at 3 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Alvan Farraker MD	(Degree or title)	22b. ADDRESS Farmington, Mo.	22c. DATE SIGNED 2/15/60
--	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE FEB. 16 1960	23c. NAME OF CEMETERY OR CREMATORY HILLVIEW MEMORIAL GARDEN NEAR FARMINGTON MO	23d. LOCATION (City, town, or county) (State)
--	----------------------------------	--	---

24. FUNERAL DIRECTOR C.H. COZEAN FARMINGTON MO	25. DATE RECD. BY LOCAL REG. Feb. 15, 1960	26. REGISTRAR'S SIGNATURE Esther P. Gulloff
--	--	---

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION

AUG 8
1962

STATEMENT BY LICENSED EMBALMER

MAR 14 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 40

P. O. Address Farmington

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.