

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008203

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 1786** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2804 Thomas</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2804 Thomas</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Debra Yvonne Fitzpatrick</u>				4. DATE OF DEATH Month Day Year <u>2-11-60</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>11-10-58</u>	9. AGE (last birthday) <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Joe Allen</u>			13b. MOTHER'S MAIDEN NAME <u>Sumria Fitzpatrick</u>			14. NAME OF HUSBAND OR WIFE <u>Baby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Josephine Lacy</u>			Address <u>2806 Thomas</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>Acute Pulmonary Edema</u>							INTERVAL BETWEEN ONSET AND DEATH <u>916.0</u> <u>16</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Swims of 95% of Body</u>	DUE TO (c) <u>Carbon Monoxide poisoning</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Choking on fire</u> <u>at home at 2804</u>							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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in PART I or PART II of item 18.) <u>Blown off about 12:54pm</u> <u>Feb 11 1960 Cause of Fire</u>							
20c. TIME OF INJURY <u>1234</u> Hour p.m. Month, Day, Year <u>2 11 60</u>	20d. INJURY OCCURRED WHILE AT WORK <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.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>		COUNTY <u>Mo</u>		STATE				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at <u>115 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Patrick Taylor Coroner</u>					22b. ADDRESS <u>1300 Clark</u>			22c. DATE SIGNED <u>FEB 16 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>			23d. LOCATION (City, town, & county) <u>St. Louis County Missouri</u>				
24. FUNERAL DIRECTOR <u>Ellis Funeral Home</u>			ADDRESS <u>2820 Stoddard</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 16 1960</u>		26. REGISTRAR'S SIGNATURE <u>Keal Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *No Embalming*
M. Smith
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.