

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009871

FILED VS MAR 28 1960

38

Primary Registration District No. 3006

Registrar's No. 182

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>			Length of stay in 1b <u>21 DAYS</u>		c. CITY OR TOWN <u>Shelbina</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>University Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>Lee</u> Last <u>FITZPATRICK</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>23</u> Year <u>1960</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>10-17-1923</u>	9. AGE (last birthday) <u>36</u>	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) <u>TRUCK DRIVER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>SHELBYNIA, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DAVE FITZPATRICK</u>			13b. MOTHER'S MAIDEN NAME <u>Mable Kirkwright</u>			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>(1943-1949)</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Medical Records Hospital</u> Address <u>UNIVERSITY</u>			
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 <u>1945 to</u>	
IMMEDIATE CAUSE (a) <u>Myemia</u>							<u>March 23 1960</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>chronic glomerulonephritis</u>							
	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 checked="" 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 <u>7:40</u> <u>3/2/60</u> to <u>3/23/60</u> and last saw him <sup>her</sup> alive on <u>3/22/60</u> Death occurred at <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Michael J. Avigian M.D.</u>				22b. ADDRESS <u>U. of Missouri Medical Center</u>		22c. DATE SIGNED <u>3/23/60</u>		
23a. BURIAL (Cremation, Removal) (Specify) <u>Burial</u>	23b. DATE <u>3-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CROOKED CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONROE COUNTY, Mo.</u>				
24. FUNERAL DIRECTOR <u>HAYES FUNERAL HOME, SHELBYNIA, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>March 23, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 31 1960

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

*Paul E. Hayes*

Licensed Embalmer No. 446

P. O. Address Shelburne

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.