

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022796

STATE FILE NUMBER

FILED VS. JUN 20 1960 118

Registration District No.

Primary Registration District No. 5439

Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <b>Gasconade</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gasconade</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Canaan Twp.</b>		Length of stay in 1b <b>3 1/2 yrs.</b>	c. CITY OR TOWN <b>Canaan</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Farm Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Bland Route 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Walter William Fitzgerald</b>			4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1960</b>		
5. SEX <b>male</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>1-9-1883</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>	11. BIRTHPLACE (City and state or country) <b>Washington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Isaac Fitzgerald</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Stockton</b>		14. NAME OF HUSBAND OR WIFE <b>rald Mary F. Crider Fitzge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Mary F. Fitzgerald Bland, Mo</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>Left Hemiplegia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis</b> DUE TO (c) <b>Hypertension</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 dys.</b> <b>4 dys +</b>
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 Month, Day, Year a.m. p.p.					
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>6-3-60</b> to <b>6-7-60</b> and last saw him alive on <b>6-7-60</b> Death occurred at <b>4:15p</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paula Brenner, M.D.</b> (Degree or title)			22b. ADDRESS <b>Owensville, Mo.</b>		22c. DATE SIGNED <b>6-9-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>6-10-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grove Dale Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Bland, Mo.</b>	
24. FUNERAL DIRECTOR <b>Gottenstroeter F. Home Owensville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>June 10, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Maxine Jappmeyer</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**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 *Me*, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Mulford 9/7/20*

Licensed Embalmer No. 382

P. O. Address OWENSU

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.