

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046810

FILED VS DEC 21 1960

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 487

|  |   |  |  |   |   |  |
|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Marion</u>   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> COUNTY <u>Marion</u> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>  |   | Length of stay in 1b   | c. CITY OR TOWN <u>Hannibal</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. Levering Hospital</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <u>1416 Broadway</u>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RUBY</u> Middle <u>FITZSIMMONS</u> Last <u>FITZSIMMONS</u>   |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>4</u> Year <u>1960</u>  |   |   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/8/1885</u>  | 9. AGE (last birthday) <u>77</u>  | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>20</u>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country) <u>Frankford Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u>  |  |
| 13a. FATHER'S NAME <u>Simeon Robertson</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Lou Unsell</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>Ray Fitzsimmons</u>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |   | 16. SOCIAL SECURITY NO.  | 17. INFORMANT Address <u>Mrs. L. Robertson Hannibal Missouri</u>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarct a</u>  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |   | DUE TO (b) <u>arterior sclerotic heart disease</u>   |  | 4 yrs   |   |  |
|  |   | DUE TO (c) <u>hypertension</u>   |  | 5 yrs   |   |  |
| 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.<br><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<br>Hour <u>          </u> a.m. <u>          </u> p.m.<br>Month, Day, Year <u>          </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.)                  | 20f. CITY, TOWN, OR LOCATION   | COUNTY   | STATE   |   |  |
| 21. I attended the deceased from <u>1932</u> , to <u>          </u> and last saw her <u>          </u> alive on <u>5/8/60</u> .<br>Death occurred at <u>8:00 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |   |   |  |
| 22a. SIGNATURE <u>F. E. Sultzman M.D. F.A.C.S.</u> (Degree or title)   |   |  | 22b. ADDRESS <u>115 N. 5th St., Hannibal, Mo</u>   |   | 22c. DATE SIGNED  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>12/6/1960</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>  | 23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>   |   |   |  |
| 24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Missouri</u>  |   | ADDRESS  | 25. DATE RECD. BY LOCAL REG. <u>12/9/60</u>  | 26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Lillian M. Norman</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 H Crawford Smith

Licensed Embalmer No. 7814

P. O. Address Hannibal, Miss

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.