

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043359

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 3099 Registrar's No. 238

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 9 6 1962	
1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> Length of stay in 1b <u>3 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.F.D. # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY IRENE FITZPATRICK</u>	
4. DATE OF DEATH Month Day Year <u>November 19, 1962</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>9/3/1880</u>
9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife in own home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Reger, Sullivan Co. Mo.</u>
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Trumbo</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Nance</u>
14. NAME OF HUSBAND OR WIFE <u>Frank Leo Fitzpatrick (deceased)</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 <u>Francis Leo Fitzpatrick, Brookfield, Mo.</u> Address	INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease and 4 years</u> DUE TO (c) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Cardiovascular disease; Hypertension</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 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.m.	
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>1959</u> to <u>Nov. 19 1962</u> and last saw her alive on <u>11-19-62</u> Death occurred at <u>3:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>George [Signature]</u> (Degree or title)	22b. ADDRESS <u>Marceline, Missouri</u>
22c. DATE SIGNED <u>11-20-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 21, 1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-20-62</u>
26. REGISTRAR'S SIGNATURE <u>Lenna Walter</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

VS 300 Rev. 4/59
 0521
 20580
 3
 4 1
 5 2
 6
 7 0
 8 0
 9/20.1
 10
 11
 124-0
 132-0

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *B. J. Lindley*
Licensed Embalmer No. *1870*

P. O. Address *Chillicothe, Mo.*

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.