

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000351

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 57

FILED JAN 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H.C. Senne, M.D.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 12 Days	c. CITY OR TOWN Forest City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Forest City Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First TERESA Middle Last FITZMAURICE		4. DATE OF DEATH Month January Day 17 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1902
9. AGE (last birthday) 60		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Hopkins, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME James E. Hartnett	
13b. MOTHER'S MAIDEN NAME Katherine Huebner		14. NAME OF HUSBAND OR WIFE Michael Fitzmaurice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Michael Fitzmaurice Forest City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia			INTERVAL BETWEEN ONSET AND DEATH 9 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) 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 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 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 St. Joseph, Mo.		COUNTY STATE
21. I attended the deceased from 3-31-62 to 1-17-63 and last saw her alive on 1-17-63 Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H.C. Senne M.D. (Degree or title)		22b. ADDRESS 223 n 7th St. Joseph Mo	22c. DATE SIGNED 1-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 19, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR H. O. Sidenfaden & Son ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Jan. 21, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON



Student in class

STATE OF MISSOURI

DEPARTMENT OF HEALTH

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Permit issued 11/8/63

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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 *Robert H. Gable*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.

MISSOURI DEPARTMENT OF HEALTH