

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

10612

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *Ex. Route to City Hall #1*)

File No.....
Registered No. *2616*
St. Ward)

2. FULL NAME

Thomas Fitzgibbon
(a) Residence. No. *911 Market St.* St. *25* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Unknown</i>
-----------------------	----------------------------------	--

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE YEARS <i>alt 65</i>	MONTHS <i>✓</i>	DAYS <i>✓</i>	IF LESS than 1 day,hrs. ormin.
-------------------------------	--------------------	------------------	--

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT (Address) *John J Hurley, 2600 Olive*

15. FILED 19 *May 11 1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/3/30* 19

17. *No Physician attended*
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h..... alive on _____, 19____, and that death occurred, on the date stated above, at *12:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
935

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

90B

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? *yes.*

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) *J. W. Kerner* M.D.

3/14/30 (Address) *Dep. Coroner*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Notterfield *3/18 1930*

20. UNDERTAKER ADDRESS

Zeigler Bros *Cherokee*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

