

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

Do not use this space.

24797

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis Mo.* (No.)

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *6956*
St. Ward)

2. FULL NAME

John Fitzpatrick

(a) Residence. No. *1025 N 18th* St., *13* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *28* yrs. *5* mos. *12* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Feb. 1, 1902

7. AGE

YEARS
28

MONTHS
5

DAY
11

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14. INFORMANT

(Address)

*W.R. Summers
5300 Arsenal*

JUL 14 1930
FILED

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 12th 1930

17.

I HEREBY CERTIFY, That I attended deceased from *Jan. 1st* 19*28* to *July 10th* 19*30* that I last saw him alive on *July 11th* 19*30*, and that death occurred, on the date stated above, at *12:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Acute Transferrinemia
92A*

CONTRIBUTORY (SECONDARY)

900 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

0 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no*. DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *W.R. Summers*, M. D.

7-12, 1930 (Address) *5300 Arsenal*

*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

Calvary Cemetery

7-15, 1930

20. UNDERTAKER

ADDRESS *4109 Manchester*

Kriegelsheim Co

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

64



5