

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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County Andrew Registration District No. 13  
Township \_\_\_\_\_ Primary Registration District No. H010—  
City Savannah (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 3797  
Registered No. \_\_\_\_\_

2. FULL NAME

Joseph E Fritchman  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) w  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma A

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
71 — 7

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Morland Co Penn

13. NAME John Fritchman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

15. MAIDEN NAME Susan Linn

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT Fred Fritchman  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Savannah DATE 2-21 1934

19. UNDERTAKER E. G. Breit  
(ADDRESS) Savannah no

20. FILED 2/21 1934 Wm A. R. King  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 19 .1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 11:30 a.m.

The principal cause of death and related causes of importance were as follows:  
Self Inflicted Gun Shot Wounds Date of onset \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Suicide Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) M. L. Hellyday M.D.  
(Address) Fleemore Mo  
Cowan Andrew Co Mo

