

AUG 16 1939

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

25330

Do not use this space.

1. PLACE OF DEATH

(a) County Cass Registration District No. 156
(b) Township Harrisonville Primary Registration District No. 4090
(c) City Harrisonville (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred 58 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

John Lawson Fitch
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 4-1871

7. AGE YEARS 68 MONTHS 2 DAYS — If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hotel Owner
9. Industry or business in which work was done, as 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) Cass Co Mo.13. NAME Samuel Fitch14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky15. MAIDEN NAME Sarah Fitch16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky17. INFORMANT (ADDRESS) Alta C. Stephenson
Harrisonville Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Benton Mo. DATE 8/5 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) RUNNEL SURGER'S
HARRISONVILLE, MO.20. FILED Aug 6 1939 Boedensley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 4 1939

22. I HEREBY CERTIFY, That attended deceased from May 20 1933, to Aug 4 1939
I last saw him alive on Aug 4 1939. Death is said to have occurred on the date stated above, at 5:00 a.m.
The principal cause of death and related causes of importance were as follows:

Myocardosis
Malignant Myopia

Other contributory causes of importance:
Malignant Myopia

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? _____ 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) J. S. Triplett M. D., M. D.745 (Address) Harrisonville, Mo.

By 7/1/41 (Licensed Embalmer's Statement on Reverse Side)

N. E.—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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Ernest Reunburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville

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 this body is not embalmed, above space should be left blank.