

No. 2  
4-13-40  
-17-39  
X 23159

APR 15 1941  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11477

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 605  
Primary Registration District No. 4359

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town Rural New Madrid Mo.  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Thos. Lee Fitzgerald  
3. (b) If veteran, name war   
3. (c) Social Security No.

4. Sex Male 5. Color of race W.  
6. (a) Single, widowed, married, divorced   
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive  years  
7. Birth date of deceased Jan. 20 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 2 Days 6  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Madrid Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

12. Name Wm. H. Fitzgerald  
13. Birthplace Blytheville Ark  
(City, town, or county) (State or foreign country)  
14. Maiden name Theresa M. Nest  
15. Birthplace Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Rizer  
(b) Address Malden Mo.

17. (a) Burial (b) Date thereof 3-27-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Malden Cem.

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 4-1-41 (b) Dr. G. W. H. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County New Madrid  
(c) City or town Malden R.I. 72  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar. day 26th  
year 1941 hour 11:15 A minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from March 23  
1941 to March 26, 1941.  
that I last saw him alive on March 26, 1941.  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia.  
Due to Asphyxia - 1 week  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:   
Of operations \_\_\_\_\_  
Of autopsy   
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) 2  
(b) Date of occurrence 3-27-1941  
(c) Where did injury occur? 5011  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

5011 (Specify type of place)  
While at work?  Means of injury to  
23. Signature Dr. G. W. H. ... M.D. or other \_\_\_\_\_  
Address Malden Date signed Mar 27 1941

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2002

**RECEIVED**

District Health Officer No. 2

District File Number 491 - 481

Date Filed 4/11/41

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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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**