

S. No. 2  
-11-10-39  
5-17-39  
I K21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

APR 15 1941  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12176

State File No. \_\_\_\_\_

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1452 S. Conway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community Permanent residence  
years, months or days)

3. (a) PRINT FULL NAME Mildred Fitzpatrick

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Wilson Fitzpatrick 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased 10 20 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Marshall Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Joseph Hawpe

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Lynwood Fitzpatrick

(b) Address 1452 S. Conway

17. (a) Burial (b) Date thereof 3 22 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall

18. (a) Signature of funeral director F. D. Ferguson

(b) Address Marshall Mo.

19. (a) 3-22-41 (b) D. J. Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1452 S. Conway  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19  
year 1941 hour 10 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to April 19, 1941  
that I last saw her alive on April 19, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to \_\_\_\_\_  
Due to Hypertension

Other conditions 12 W  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

712  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 3/22/41

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-11-41

**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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall

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.