No. 2
-1-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 61-H 27419

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 3077

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. Gen Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 41 yrs (Specify whether years, months or days)
In this community: 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City Mo (If outside city or town limits, write "RURAL")
(d) Street No.: 1116 Prospect (If rural, give location)
(e) Citizen of foreign country? (Yes or No): No
If yes, name country:

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3. (a) PRINT FULL NAME: SARAH ELLEN FITZPATRICK
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, or divorced: Widow
6. (b) Name of husband or wife: John Fitzpatrick
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Mar. 11 1865 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
76	45	3	hr. min.

9. Birthplace: Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: Finn
13. Birthplace: Mo (!) (City, town, or country) (State or foreign country)
MOTHER 14. Maiden name: No Record
15. Birthplace: No Record 0 (City, town, or country) (State or foreign country)
16. (a) Informant: John Fitzpatrick
(b) Address: 2509 Olive
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 16 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: St Mary's Cem
18. (a) Signature of funeral director: Muel Forter
(b) Address: 918 Brooklyn
19. (a) 8/15/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 8-14-41 day: year: hour: minute: 12 30 A.M.
21. I hereby certify that I attended the deceased from: Coroner to: 19; that I last saw the deceased alive on: 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Bilateral bronchopneumonia — Duration
Due to: Fracture left femur
Due to: Injury by fall
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 1/8 6 A 1/28 10
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): Accident
(b) Date of occurrence: 7-18-41
(c) Where did injury occur? K.C. (City or town) 123 (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? fell down stairs (Specify type of place)
While at work? (Specify) Means of injury:

23. Signature: Willis M. Tichler (M. D. or other) 3
Address: K.C. Mo. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. Clair Sheppard

Licensed Embalmer No. 4179

P.O. Address N.C. Na

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.