

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33076

State File No. _____

OCT 19 1943
Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **8926**

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Desloge Hospital
 (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 days3. (a) PRINT FULL NAME **FITZGERALD, WILLIAM PATRICK**3. (b) If veteran, name war no 3. (c) Social Security No. --4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Margaret Fitzgerald 6. (c) Age of husband or wife if alive 46 years7. Birth date of deceased Feb. 11, 1888
 (Month) (Day) (Year)8. AGE: Years Months Days If less than one day
55 7 27 hr. min.9. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)10. Usual occupation Retired Welder

11. Industry or business _____

MOTHER FATHER
 12. Name William P. Fitzgerald
 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Carrie Stegmeyer
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Fitzgerald(b) Address 2624 Walton Road17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-43
 (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director Jos. W. Clark(b) Address 1025 9th Street Ave.19. (a) OCT 9 1943 (Data received local registrar) (b) J. F. Budick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Louis **96**
 (c) City or town Yanick Park **0**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2624 Walton Rd. **HR**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8
 year 1943 hour 8:00 minute _____ A. M.21. I hereby certify that I attended the deceased from 6-30-43
 _____, 19____, to 10-8-43, 19____;that I last saw him 54 alive on 10-8-43, 19____;
 and that death occurred on the date and hour stated above.Immediate cause of death Rheumatic HT Disease **uncertain**
 Duration _____

Due to _____

Due to _____ **926**Other conditions _____
 (Include pregnancy within 3 months of death)Major findings: _____
 Of operations _____Of autopsy Rheumatic HT Disease 2 calcification
stenosis of mitral valve - cardiac
circulation - congestion of organs
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____23. Signature J. F. Budick (M.D. or other) **MD**Address 1325 S. Grand Date signed _____

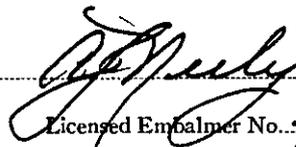
(Licensed Embalmer's Statement on Reverse Side)

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

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. 3225

P. O. Address 425 Hodiamout Ave

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.