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FILED APR 23 1944
Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **67**

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 3/4 hours
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte 83
(c) City or town Wester
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marshall Lee Fitzgerald

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Fitzgerald 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 31 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 6 9 - hr. - min.

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

10. Usual occupation Tenant Farmer

11. Industry or business _____

12. Name John Allen Fitzgerald

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

14. Maiden name Sally Serapena

15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Pt. (Marshall Fitzgerald)

(b) Address Wester, Mo.

17. (a) Burial (b) Date thereof Mar 12, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wester, Mo.

18. (a) Signature of funeral director W. R. Dungan

(b) Address Wester, Mo.

19. (a) 3-11-1944 (b) E. O. R. Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1944 hour 5:00 minute - P.M.

21. I hereby certify that I attended the deceased from March 10,
2:00 P.M. 1944, to March 10, 5:00 P.M. 1944;
that I last saw him alive on March 10, 1944 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of aorta ✓
Due to Liberty Arterio Sclerosis
Due to Sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy See above

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. Johnson (M. D. or other) M.D.
Address Cancer Hospital Date signed _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-20-44

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.....

W. R. Vaughn

Licensed Embalmer No.....

4023

P. O. Address.....

Weston Mo.

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.

Registration District No. 38 Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(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
years, months or days)

3. (a) PRINT FULL NAME Marshall Lea Fitzgerald

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 3
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days _____ Unless than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1944 year, hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of aorta

Due to probably atherosclerosis

Due to This was not due to a syphilitic condition

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature J. V. Ackerman (M. D. or other) _____ Date signed _____
Address State Cancer Hosp

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

14080