

3. No. 2  
-12-45  
5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36954

FILED DEC 9 1946

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 1602

Registrar's No. 4908

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2104 Holly  
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Fitzgerald

3. (b) If veteran, name war no

3. (c) Social Security No. 487-16-7116

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26  
year 1946 hour 11 minute 40 P. M.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 21 1889  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 21 1946 to Nov. 26 1946  
that I last saw him alive on Nov. 26 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 8 Days 5  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Carcinoma of rectum with metastases to liver-broncho-pneumonia

Due to \_\_\_\_\_

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

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Employee St. Mary's Hospital

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

Of autopsy See above

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name William Fitzguald

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

14. Maiden name Johanna Kaver

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

16. (a) Informant Mrs. Bridget Barrett

(b) Address 2104 Holly R. C. Mo

17. (a) Burial (b) Date thereof 11-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Hosp.

18. (a) Signature of funeral director J. F. O'Donnell, Co

(b) Address 3256 Broadway

19. (a) 11-28-46 (b) Thelma Holmes  
(Date received local registrar) (Registrar's signature)

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 Wm W. Hart (M.D. or other) \_\_\_\_\_  
Address Med. Dir. Gen'l Hosp. Date signed 11-26-46

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

*Dr. Fitzgerald*

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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 *Park G. Rowe*  
Licensed Embalmer No. *2347*  
P. O. Address: *N. E. 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.**