FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 6 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34127

Primary Registration District No. 1005

Registrar's No. 9241

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: Masonic Home of Missouri 5
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 5351 Delmar
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lillie May Fitzsimmons

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced widowed 2

6. (b) Name of husband or wife Wm. N. Fitzsimmons

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

7. Birth date of deceased July 4, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	3	20	hr. min.

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

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Henry Thuman
13. Birthplace Hanover, Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Belle Higgs
15. Birthplace Fort Donaldson, Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Rothe
(b) Address 5351 Delmar Ave. St. Louis

17. (a) Cremation (b) Date thereof Oct 27 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crmeatory

18. (a) Signature of funeral director Valvin F Feutz
(b) Address 4828 Nat Bridge Blvd

19. (a) OCT 26 1948 (b) J. B. Casaler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24
year 1948 hour 7.50 minute P M.

21. I hereby certify that I attended the deceased from Dec. 11, 1944 to Oct. 24, 1948 that I last saw her alive on Oct. 24, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Trombosis	5 dys
Hypertension	2 yrs
Chronic Bronchitis	3 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 508 N. Grand Blvd Date signed 10-24-48

Jefferson City Printing Co. (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.....

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

working under my personal supervision.

Signed John A. Mlinar

Licensed Embalmer No. 4186

P. O. Address St Louis 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 100

Registration District No. 315 Primary Registration District No. 1003 Registrar's No. 9241

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis

(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)

In this community

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

3. (a) PRINT FULL NAME Lillie M Fitzsimmons

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 4 (Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

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

MOTHER

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

NOV 10 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK

S-34127