V.S. No. 300
Rev. 10.46

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10427

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 2142

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4259 Gano Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4259 Gano

3. NAME OF DECEASED (Type or Print): a. (First) Eliza b. (Middle) J c. (Last) Fitzwater

4. DATE OF DEATH (Month) (Day) (Year): Mar. 4. 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 11. 1859
9. AGE (In years last birthday): 90 — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Hannibal, Missouri
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: John Martin
13b. MOTHER'S MAIDEN NAME: Mary Jane James
14. NAME OF HUSBAND OR WIFE: John S. Fitzwater

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mae Gausepohl 4259 Gano Ave.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 4201
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 8, *19*50, *to* March 4, *19*50, *that I last saw the deceased alive on* March 3, *19*50, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Percy Newman M.D.
23b. ADDRESS: 3539 Hartford St.
23c. DATE SIGNED: Mar. 6. 150

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3/7/50
24c. NAME OF CEMETERY OR CREMATORY: Bethany Cem
24d. LOCATION (City, town, or county) (State): Wellston, Stl. Louis Co.

DATE REC'D BY LOCAL REG.: MAR 6 1950
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. A. Stock 2117 E. Grand.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Frank G. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.