

FILED APR 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14060
3221

318

1003

Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 30 yrs		2. STREET ADDRESS (If rural, give location) 20 South 22nd St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ruth b. (Middle) c. (Last) Fitzgerald			4. DATE OF DEATH 3 - 25 - 51		
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 11	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 35	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U S A					

13a. FATHER'S NAME Jim Fitzgerald		13b. MOTHER'S MAIDEN NAME Agnes Jones		14. NAME OF HUSBAND OR WIFE Unknown	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk Unk		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH Undet.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? DOPX	
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22. I hereby certify that I attended the deceased from 8-25, 1951, to 3-25, 1951, that I last saw the deceased alive on 3-25, 1951, and that death occurred at 8:50p m., from the causes and on the date stated above.

23a. SIGNATURE Alvin J. Thompson P. M.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 3-28-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE APR 6 1951		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REG. APR 1951		REGISTRAR'S SIGNATURE J. B. Lassiter		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS 1004 St. Charles Ave. St. Louis 10, Mo.	
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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.....

Licensed Embalmer No.....

P. O. Address.....

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.