

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 2525

Registrar's No. 0577

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (in this place) 0 4 wks.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1				STREET ADDRESS (If rural, give location) 2249 2726a Chippewa Street									
3. NAME OF DECEASED (Type or Print) THOMAS			a. (First)			b. (Middle)			c. (Last) FITZPATRICK				
4. DATE OF DEATH			(Month)			(Day)			(Year)				
5. SEX Male			6. COLOR OR RACE White			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married			8. DATE OF BIRTH Nov. 5, 1873				
9. AGE (In years last birthday) 81			IF UNDER 1 YEAR Months			IF UNDER 1 YEAR Days			IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman (retired)				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Mathew Fitzpatrick				13b. MOTHER'S MAIDEN NAME Anna Costello				14. NAME OF HUSBAND OR WIFE None					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT'S SIGNATURE OR NAME Mrs. Kate Unger - 2726a Chippewa St.				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of the esophagus</i>  ANTECEDENT CAUSES *Forble 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.								INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?  150X					
22. I hereby certify that I attended the deceased from 12-19, 1954, to 1-18, 1955, that I last saw the deceased alive on 1-18, 1955, and that death occurred at 10:40 P.m., from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <i>William Boniface OMD</i>				23b. ADDRESS 1515 Lafayette Ave.				23c. DATE SIGNED 1-19-55					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial				24b. DATE Jan. 21, 1955				24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. JAN 20 1955				REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>				25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Harker</i>				ADDRESS 3634 Gravois Ave.	

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert Wheeler*.....

Licensed Embalmer No. *212*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.