

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 26 1957

29439

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **7448**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY: (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Pac. Hosp.		Length of stay in lb 24 STREET ADDRESS 3134 Iowa Ave	
3. NAME OF DECEASED (Type or print) Robert First Ray Middle Fitzgerald Last		4. DATE OF DEATH Month 8 Day 8 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchman		10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R.R.	11. BIRTHPLACE (City and state or country) DuQuoin, Ill.
13. FATHER'S NAME Abel Fitzgerald		14. MOTHER'S MAIDEN NAME Jennie Cornelius	
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. 720-12-7861	
17. INFORMANT Wife Address		Mary E. Fitzgerald 3134 Iowa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, right Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH Several months
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 8-3-1957 to 8-8-1957 and last saw ^{her} him alive on 8-8-1957 . Death occurred at 11:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Carl Smith, M.D.		22b. ADDRESS Mo. Pac. Eng. Hosp. Assn.	
22c. DATE SIGNED 8-9-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 12, 57	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR E. J. Schnur 3125 Lafayette Ave.		25. DATE RECD. BY LOCAL REG. AUG 9 57	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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.....

Licensed Embalmer No. 40

P. O. Address 3125 9th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.