

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007848
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 517

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp.		d. STREET ADDRESS (If outside, give location) 522 Mason Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last DENNIS H. FITZGERALD		4. DATE OF DEATH Month Day Year Febr. 23, 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Municipality	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Ned Fitzgerald		13b. MOTHER'S MAIDEN NAME Unknown	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) Yes WW I		16. SOCIAL SECURITY NO. 496-22-3163	17. INFORMANT Address William E. Legg, above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 yrs.
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 a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input 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 Feb 10, 58 to Jan 25, 59 and last saw him alive on Jan 25, 59 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Michael Sulick M.D.		22b. ADDRESS 9012 Manchester Rd	
22c. DATE SIGNED 2-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-26-59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo.		25. DATE RECD. BY LOCAL REG. 2-24-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. H. Burgess*

Licensed Embalmer No. *4029*
P. O. Address *Maplewood*

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.