

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043019

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. **283** Primary Registration District No. **3074** Registrar's No. **210**

UNDECEASED

1. PLACE OF DEATH a. COUNTY SCOTT				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY SCOTT				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON		Length of stay in 1b		c. CITY OR TOWN SIKESTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 114 WAKEFIELD			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 517 PARK		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LYNNE TAYLOR FITZGERALD				4. DATE OF DEATH Month Day Year NOVEMBER 9, 1959				
5. SEX F	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-19-1922	9. AGE (last birthday) 37	IF UNDER 1 YEAR Months 8 Days 20	IF UNDER 24 HR 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 AT HOME	11. BIRTHPLACE (City and state or country) SIKESTON, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME CASPER TAYLOR		13b. MOTHER'S MAIDEN NAME MARGARET MERTZ		14. NAME OF HUSBAND OR WIFE WEDROW W. FITZGERALD				
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.	17. INFORMANT Address CATHERINE TAYLOR 517 PARK SIKESTON, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Vascular Hypertension DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4.5 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 WORK <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 10-14-1955 to 10-11-56 and last saw her ^{her} alive on 11-8-59 Death occurred at 5:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Sharon C. McClure M.D.				22b. ADDRESS Siikeston, Mo.		22c. DATE SIGNED 11/13/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-12-1959	23c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES		23d. LOCATION (City, town, or county) SIKESTON, Mo.		(State)	
24. FUNERAL DIRECTOR Wm. C. Nunnelee NUNNELEE FUN. CHAPEL			ADDRESS SIKESTON, Mo.		25. DATE RECD. BY LOCAL REG. 11-17-59	26. REGISTRAR'S SIGNATURE Mrs. Callahan		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 24 1960 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 Edward E. Funnelle

Licensed Embalmer No. 4164

P. O. Address Sikeston, 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.