

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH	
County <u>Livingstone</u>		BUREAU OF VITAL STATISTICS	
Township <u>Chillicothe</u>		Registration District No. <u>508</u>	File No. <u>1697</u>
Village _____		Primary Registration District No. <u>51674</u>	Registered No. <u>2</u>
City _____ (NO. _____)		St. _____ Ward _____	
FULL NAME <u>Catherine Fitzpatrick</u>			

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)	
DATE OF BIRTH <u>Dec. 11, 1850</u> (Month) (Day) (Year)			
AGE <u>63</u> yrs. <u>0</u> mos. <u>25</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>house wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
BIRTHPLACE (City or town, State or foreign country) <u>Born in Ireland</u>			
PARENTS	NAME OF FATHER <u>Michael Rogers</u>		
	BIRTHPLACE OF FATHER <u>Ireland</u> (City or town, State or foreign country)		
	MAIDEN NAME OF MOTHER <u>Dorothy Knowlton</u>		
	BIRTHPLACE OF MOTHER <u>Ireland</u> (City or town, State or foreign country)		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>L</u>			
(ADDRESS) <u>Lucy Starke</u>			
Filed <u>Jan 6</u> 191 <u>4</u>	Chillicothe Mo. <u>J. C. Hutton</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Jan 6, 1914</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>July 16, 1912</u> , to <u>Jan. 6, 1913</u> , that I last saw her alive on <u>Dec. 26, 1913</u> , and that death occurred, on the date stated above, at <u>10:46</u> m.	
The CAUSE OF DEATH* was as follows: <u>chronic pancreatitis</u> <u>178</u>	
Contributory (SECONDARY) <u>18</u> (Duration) <u>2</u> yrs. ___ mos. ___ ds.	
(Signed) <u>H. M. Green</u> M. D. <u>Jan. 6, 1914</u> (Address) <u>Chillicothe Mo.</u>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
Where was disease contracted if not at place of death? Former or usual residence _____	
PLACE OF BURIAL OR REMOVAL <u>Waverly Iowa</u>	DATE OF BURIAL <u>Jan 7, 1914</u>
UNDERTAKER <u>J. Mohr & Son</u>	ADDRESS <u>Chillicothe Mo.</u>