

27 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
Forest
36616

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City 480 E. Elm St. _____ Ward _____
 Registered No. 787

2. FULL NAME Letha Ann Patterson
 (a) Residence. No. 480 E. Elm St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. ~~Is~~ Married, Widowed, or Divorced HUSBAND OF (or) WIFE OF Gideon M. Patterson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-13-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 - 27

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Greene

10. NAME OF FATHER Robt. H. Brooks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo. E.

12. MAIDEN NAME OF MOTHER Letha Basswell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

14. INFORMANT Gideon M. Patterson
 (Address) Springfield Mo.

15. FILED 11-12-28 O. C. Forest WRS REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
999/10
1324 (duration) _____ yrs. _____ mos. 3 da.
 CONTRIBUTORY arterio sclerosis
 (SECONDARY) several (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
O. C. Forest (Signed) _____, M. D.
11-12-28 (Address) SPRINGFIELD, MO.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olive Cem. DATE OF BURIAL 11/12-1928

20. UNDERTAKER Alma Lohmeyer F. H. ADDRESS 534 St Louis

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.

