

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

Do not use this space.

1179

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1007
(No. St. Luke's Hospital)

File No. 1179
Registered No. 1179
St. _____ Ward _____

2. FULL NAME

John Deans Patterson

(a) Residence. No. Tomlinson & Broadway 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie Patterson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby. 9, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
80 11 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ash County
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Not known

14. INFORMANT Dr. Robert McE. Schaeffer
(Address) 3519 Greenwood

15. FILED Jan 13, 30 M. M. Casove
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Tumor
endothelioma
530

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 449

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) Stanley M. Hays M. D.

1/12, 1930 (Address) Respoty Crown

*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 DATE OF BURIAL

Forest Hill Cemetery 1-16 1930

20. UNDERTAKER ADDRESS: 323 B

Stue + McClure Hillman Plaza

K. 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.

201
2
31

