

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

DO NOT USE THIS SPACE

16547

1. PLACE OF DEATH

County..... Registration District No. 701
 Township..... Primary Registration District No. 307
 City..... (No. Central Hospital) St. Ward)

File No.
 Registered No. 5070
 St. Ward)

2. FULL NAME

Phillis M. Patterson
 (a) Residence. No. 5331 Vernon St., 5 Ward. (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>H. I. Patterson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 20 - 1896</u>		
7. AGE	YEARS	MONTHS
	<u>34</u>	<u>11</u>
		DAYS
		<u>7</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Assistant to Dentist</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer <u>Dr. Steaton Wolf</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sweden</u>		
PARENTS	10. NAME OF FATHER <u>Unknown</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 4/27 19 31

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1931 to Apr 27 1931 that I last saw her alive on Apr 26 1931 and that death occurred, on the date stated above, at 3 A.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cancer of Pancreas
46 F

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 46 F
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4/13 87

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Aspir 1
 (Signed) H. K. Smarsh M. D.
4/27 1931 (Address) 225 University Ch.

*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 <u>Oak Grove Cem</u>	DATE OF BURIAL <u>April 28</u> 19 <u>31</u>
20. UNDERTAKER <u>Craig Undertaking Co</u>	ADDRESS <u>Washington</u>

14. INFORMANT H. I. Patterson
 (Address) 404 Delmar

15. FILED 20 1931 REGISTRAR W. J. Starnes

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

