

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

18012

Do not use this space.

REC'D JUN 16 1938

1. PLACE OF DEATH

(a) County Christian Registration District No. 184
 (b) Township South Bellburg Primary Registration District No. 0270
 (c) City Spokane, Mo. (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred _____ mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ella Mae Patrick 312
 (a) Residence, No. Spokane, Missouri St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Charley Patrick

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 5 - 1887

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, _____ hr. or _____ min.
50 3 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. House Wife
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) James St. Leon, Mo.13. NAME Jae Roberts14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown15. MAIDEN NAME Mally Redman16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown17. INFORMANT (ADDRESS) Charley Patrick, Spokane, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Spokane Co., Mo. DATE 4/3, 193819. FUNERAL DIRECTOR (NAME) (ADDRESS) B. C. Flyper, Garden, Mo.20. FILED May 31, 1938 Luella Leonard Local Registrar.

MEDICAL CERTIFICATE OF DEATH.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 1, 193822. I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1938 to April 1, 1938I last saw her alive on Mar. 29, 1938 Death is said to have occurred on the date stated above, at 6:30 a.m.

The principal cause of death and related causes of importance were as follows:

Subv Pneumonia Date of onset _____

Other contributory causes of importance:

Paralysis Right side of Body for 2 years;

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) J. H. Wade, M. D.
Gark, M. D.

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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,

B. C. Klepper

or by **Forest Klepper**

Registered Apprentice No. **143**, working under my personal supervision.

Signed

B. C. Klepper

Licensed Embalmer No. **Mo. 2178**

P. O. Address **Ozark, Missouri**

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 this body is not embalmed, above space should be left blank.

Missouri State Board of Health
REGISTERED EMBALMER

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

18012
Do not use this space.

1. PLACE OF DEATH
 (a) County Christian Registration District No. 184
 (b) Township South Galloway Primary Registration District No. 6270
 (c) City..... (d) Street No.....
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ella Mae Patience
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>30</u>	<u>3</u>	<u>26</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....
 9. Industry or business in which work was done, as saw mill, bank, etc.....
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

FATHER

13. NAME.....
 14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME.....
 16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT (ADDRESS).....
 18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE..... 19.....
 19. FUNERAL DIRECTOR (ADDRESS).....
 20. FILED 7-11 19 35

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 1 19 38

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia Date of onset 10/5
 Other contributory causes of importance:
Paralysis right side of body for 12 yrs. cerebral thrombosis
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify J. H. Wade, M. D.
 (Signed) J. H. Wade
 (Address) Clark

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

Local Registrar.

S-18012

1938