

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

32269
Do not use this space.

1. PLACE OF DEATH

(a) County Ballast Registration District No. 241
 (b) Township 1. Benton Primary Registration District No. 3354
 (c) City Buffalo (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. J. Patterson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 27-1852
 7. AGE YEARS 87 MONTHS 2 DAYS 8 IF LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
 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) Ohio

FATHER 13. NAME Philip Nicholson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

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

17. INFORMANT Thomas Patterson (ADDRESS) Buffalo Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Cave town DATE 5-6-39

19. FUNERAL DIRECTOR (NAME) L. B. Jones (ADDRESS) Buffalo Mo

20. FILED 4/27 1939 Henny Morrow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-5-39
 22. I HEREBY CERTIFY, That I attended deceased from April 20, 1939, to May 5, 1939
 I last saw her alive on May 5, 1939. Death is said to have occurred on the date stated above, at 1 P m.

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

~~Chronic heart disease~~
Chronic Heart Disease
 Other contributory causes of importance: 100 C
Chronic Myocarditis - arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chronic Was there an autopsy? no

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) Wanda O. Hammer, M. D.
Buffalo, Mo. (Address)

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.

RECORDED 1939

50M-1-12-35 I X1402B

RECEIVED

District Health Officer No. 7

District File Number 7-39-14-89

Date Filed 10-12-39

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,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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.