

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4179

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Mansas City
(c) Name of hospital or institution: M.C. Sun Hosp.
(d) Length of stay: In hospital or institution 17 days
In this community 62 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town Mansas City
(d) Street No. 2627 Victor
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Thomas Jackson Patterson

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced WID

6. (b) Name of husband or wife MRS LAURA BELL PATTERSON 6. (c) Age of husband or wife if 74 years

7. Birth date of deceased April 8 1866

8. AGE: Years 80 Months 7 Days 23 If less than one day hr. _____ min. _____

9. Birthplace LIVINGSTONE COUNTY MO

10. Usual occupation CONTRACTOR

11. Industry of business _____

MOTHER FATHER
12. Name John N Patterson
13. Birthplace N.Y.
14. Maiden name Nancy Jackson
15. Birthplace N.Y.

16. (a) Informant's own signature Richard Clerk

(b) Address M.C. Sun Hosp.

17. (a) Cremation (b) Date thereof 10-31-39

(c) Place: burial or cremation Cremation

18. (a) Signature of funeral director D. W. Newcomes

(b) Address 10/31/39

19. (a) 10/31/39 (b) M. N. Browne

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31 year 1939 hour 12 minute 55 a.m.

21. I hereby certify that I attended the deceased from Oct 14 1939 to Oct 31 1939 that I last saw him alive on Oct 31 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Absence of left kidney
Urogenital; Dist. operative
Due to Resection
Re. Subur. Prostate
Due to Hypertrophy of Prostate
Quercinosis with infection
Other conditions and edema
(Include pregnancy within 3 months of death)

Major findings: 108
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature P. De Marco (M. D. or other) M.D.
Address Switz Gen Hosp Date signed 10/31/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-30 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.

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.....

H. O. Newcomer Jr.

Licensed Embalmer No. *40431*

P. O. Address *St. Louis, Mo.*

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.