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X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30882**
3445
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Delmar Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 0 211 - W - 15 st
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 40 years.

3. (a) PRINT FULL NAME MRS. GRACE PATTISON

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife A. K. Pattison 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Dec 19 - 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Canada
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 9

12. Name Cronkite

13. Birthplace Canada
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace " no record
(City, town, or county) (State or foreign country)

16. (a) Informant A. K. Pattison

(b) Address 211 - W - 15 st

17. (a) Burial (b) Date thereof Sept - 3 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Broadway

19. (a) Sept. 3, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28
year 1940 hour 11 minute 30 a M.

21. I hereby certify that I attended the deceased from 8-27, 1940, to 8-28, 1940
that I last saw her alive on 8-28-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis ?

Due to Pulmonary infarction and
atherosclerosis 8-11-40

Other conditions Fracture of humerus 8/11/40
(Include pregnancy within 3 months of death)
with atelectasis of lungs.

Major findings: W
Of operations 186
Of autopsy as above 110

PHYSICIAN 186
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 8-11-40

(c) Where did injury occur? Kansas City, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? fall (Specify type of place) (e) Means of injury

23. Signature Robert M. Parker (M. D.)

Address 736 Argyle Date signed 8-29-40

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

MOTHER FATHER

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.....

Daniel C. Browning

Licensed Embalmer No.

2724

P.O. Address.....

K.E. no

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, fact should be so stated above.