

No. 2  
-11-10-39  
1-13-39  
10-10-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. Glenn

42562  
1038

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

I. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Enroute to Hospital in ambulance  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days) 3

3. (a) PRINT FULL NAME Olive Jane Patten

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Elwood Patton 6. (c) Age of husband or wife if alive Dec 1878 years

7. Birth date of deceased Nov. 9 1878  
(Month) (Day) (Year)

8. AGE: Years 62 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Clark County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business 9

FATHER { 12. Name John Laney 9  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Myles Patton  
(b) Address Galena, Missouri

17. (a) Burial (b) Date thereof Dec. 30 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Prairie Grove

18. (a) Signature of funeral director L.B. Jones 984  
(b) Address Buffalo, Missouri

19. (a) 12-30-40 (b) W. E. Hauler  
(Date received local registrar) (Registrar's signature) Address Springfield, Mo. Date signed 12-30-40

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Route # 8  
(If outside city or town limits, write "RURAL")  
(d) Street No. Springfield  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28  
year 1940 hour 8 minute 30 a. M.

21. I hereby certify that I attended the deceased from August 2, 1940, to Dec 28, 1940;  
that I last saw her alive on Dec 28, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure Duration 12 hrs.

Due to Acute Coronary Thrombosis

Due to Coronary Sclerosis 3 years

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94

Of autopsy

PHYSICIAN

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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 12-30-40

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

**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. 2457

P. O. Address Mayfield

**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.**

X