

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27374**  
Registrar's No. **3032**

X26390

Registration District No. **WIP SEP 12 1941 99**

Primary Registration District No. **1002**

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

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: 6200 St. John Ave.  
2nd Floor—Montgomery Ward & Co.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 22 Years (Specify whether years, months or days) 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8904 Thompson Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th  
year 1941 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from 10:00 PM to 10:00 PM, 1941, that I last saw alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Acute Pulmonary Edema  
Due to Hypertensive Myocarditis  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mrs. Ossa B. Patterson

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mr. David Metz Patterson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 2 1866  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>7</u>	_____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Richard Lytle

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

14. Maiden name Arretta Travers

15. Birthplace Nanta Cape  
(City, town, or county) (State or foreign country)

16. (a) Informant Serlie Patterson  
(b) Address 8904 Thompson

17. (a) Burial (b) Date thereof Aug. 11, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation Mt. Washington Cem.

18. (a) Signature of funeral director M. H. Newcomer, Sone  
(b) Address 9401 Brush Creek Blvd.

19. (a) 9/11/41 (b) M. H. Crow  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature Russell W. Fox (M. D. or other) 3  
Address Kan Date signed \_\_\_\_\_

**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

*George M. Collins*

Licensed Embalmer No.

*3839*

P. O. Address

*2401 S.W.*

**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.**