

FILLED NOV 12 1941

Registration District No. \_\_\_\_\_

Primary Registration District No. 3006

Registrar's No. 285

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
The Ellis Fischel State Cancer Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21  
year 1941 hour 2 minute 55 P.M.  
21. I hereby certify that I attended the deceased from 10-17-41  
to 10-21, 1941  
that I last saw him alive on 10-21, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: surgical shock  
Duration \_\_\_\_\_

Due to: Carcinoma of uterus 4 mo  
Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: Carcinoma of uterus  
Of operations: \_\_\_\_\_  
Of autopsy: none  
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 \_\_\_\_\_  
23. Signature Ingen M. Ponicker (M. D. or other) Om d  
Address Ellis Fischel State Cancer Hospital signed 10/21/41

3. (a) PRINT FULL NAME Stella Ethel Patton

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

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

6. (b) Name of husband or wife Robert Patton 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Feb 5 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 8 16 hr. \_\_\_\_\_ min.

9. Birthplace Cass Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

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

12. Name William Northcutt

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

14. Maiden name Elizabeth Davidson

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

16. (a) Informant Hospital Record

(b) Address Columbia, Mo

17. (a) Burial (b) Date thereof 10/23/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garden City Cemetery

18. (a) Signature of funeral director J. M. Koffman

(b) Address Garden City, Mo.

19. (a) 10/23/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

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

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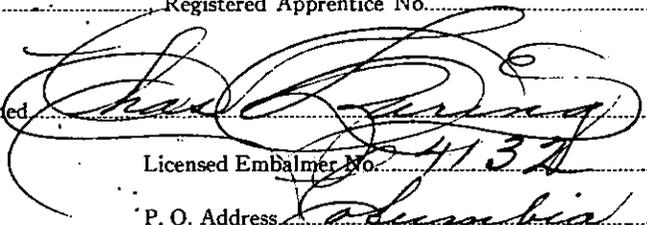
**STATEMENT BY LICENSED EMBALMER**

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. 4137

P. O. Address Columbia, N.Y.

**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.**