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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25809

FILED AUG 7 1943 282

State File No. \_\_\_\_\_

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

Primary Registration District No. 3055

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Bolivar  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk

(c) City or town Bolivar  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Leonia PATTERSON

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased January 15 1867  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	6	11	hr. _____ min. _____

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

10. Usual occupation housewife

Industry or business \_\_\_\_\_

12. Name Alford Biven

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

14. Maiden name Orwick

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

16. (a) Informant Wella Long

(b) Address Bolivar, Missouri

17. (a) Burial (b) Date thereof 7-28-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barren Creek

18. (a) Signature of funeral director Hutchison & Co.

(b) Address Bolivar, Missouri

19. (a) July 29, 1943 (b) Alice Allen  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1943 hour 10:30 minute P. M.

21. I hereby certify that I attended the deceased from July 25, 1943, to July 26, 1943, that I last saw her alive on July 26, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: A Heart Attack ✓ Duration 2 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: (Include pregnancy within 3 months of death)

Major findings: 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? \_\_\_\_\_ (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 J. N. Bridges (M. D. or other) \_\_\_\_\_

Address Bolivar Date signed July 29 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER - FATHER

1274 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 7-43-770

Date Filed 8-6-43

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.....

*Carl P. Hill*  
Licensed Embalmer No. 3756

P. O. Address..... Bilwara

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

AUG 21 1946

Registration District No. 282

Primary Registration District No. 3005

Registrar's No. 27

## 1. PLACE OF DEATH:

- (a) County Polk  
 (b) City or town.....  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution..... (Specify whether

In this community.....  
years, months or days)3. (a) PRINT  
FULL NAMELeonia Patterson

3. (b) If veteran,
- 
- name war.....

3. (c) Social Security
- 
- No.....

## 4. Sex

F5. Color or  
race W

6. (a) Single, widowed, married,
- 
- divorced
- Widow

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
- 
- alive..... years

7. Birth date of deceased.....

(Month)

(Day)

(Year)

## 8. AGE:

Years

Months

Days

If less than one day

766151861

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

- (b) Address.....

17. (a).....

(Burial, cremation, or removal)

- (b) Date thereof.....

(Month) (Day) (Year)

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a).....

(Date received local registrar)

- (b).....

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....  
 (c) City or town.....  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.....  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- July
- day
- 26
- 
- year
- 1946
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;

that I last saw him/her alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death 9 heart attack DurationDue to Endocarditis andAtherosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Due to.....

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

MOTHER, FATHER

SUPPLEMENTARY

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

23. Signature
- J. N. B. ...
- (M. D. or other)

Address..... Date signed.....

S-25809