

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33903

State File No.

4224

FILED NOV 1 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo. Blue-Tship.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8108 Independence Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Francis Marion Patterson

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

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

6. (b) Name of husband or wife Lydia Naomi Patterson 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased April 22, 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 12
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Green Patterson
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. J. C. Robinson
(b) Address 8108 Independence Ave. K.C.Mo.

17. (a) Burial (b) Date thereof Oct 9-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indop. Ave. K.C.Mo.

19. (a) 10-5-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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. 8108 Independence Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4
year 1943 hour 4 minute 45 P M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart

Due to Chassis

Due to 3rd

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Ingestion & history

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) _____
(M, D or other) _____

23. Signature [Signature] (M, D or other) _____
Address [Address] Date signed 10/10/43

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

1105-Hand

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.....

P. O. Address.....

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.