

NOV 29 1943

Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **10120**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 month**
 In this community **17 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis,** **17**
(If outside city or town limits, write "RURAL") **718**
 (d) Street No. **3135 Spruce**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Robert Patton**

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

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

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

7. Birth date of deceased **July 17, 1888**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	2	11	hr. _____ min. _____

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

10. Usual occupation **Odd Jobs**

11. Industry or business **Joseph Patton**

12. Name **Miss.**

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

14. Maiden name **Julia Dickman**

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

16. (a) Informant **Shirley M. Smith**

(b) Address **2601 N. Whittier**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-19-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **Jas. Ryan**

(b) **5800 Arsenal St**

19. (a) **NOV 18 1943** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **28,**
 year **1943** hour **7** minute **20** A. M.

21. I hereby certify that I attended the deceased from **August 28,** 19 **43** to **September 28,** 19 **43**

that I last saw him alive on **September 28,** 19 **43** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach**

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 **C. M. Jackson** (M. D.)

Address **2601 Whittier** Date signed **11/18/43**

Duration **Unk.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

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.