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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23740

FILED OCT 21 1944

Registration District No. 1402 Primary Registration District No. 1600 Registrar's No. 1017

1. **PLACE OF DEATH:**
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mercy Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Kansas (b) County Brown
(c) City or town Hiawatha
(If outside city or town limits, write "RURAL")
(d) Street No. 526½ Oregan
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles E. Patton
3. (b) If veteran, name war
3. (c) Social Security No. 510-148-110
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Reeva
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased July (Month) 10 (Day) 1884 (Year)

8. AGE: Years 60 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Crockett (City, town, or county) Va. (State or foreign country)
10. Usual occupation Filling Station
11. Industry or business

MOTHER FATHER
12. Name David W. Patton
13. Birthplace Crockett (City, town, or county) Va. (State or foreign country)
14. Maiden name Josie Ways
15. Birthplace Crocket (City, town, or county) Va. (State or foreign country)

16. (a) Informant Mrs. Reeva Patton
(b) Address 526½ Oregan
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1944 (Month) (Day) (Year)
(c) Place: Burial or cremation Hiawatha, Kansas.
18. (a) Signature of funeral director Herman W. Siderfaden
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) 10-20-44 (Date received local registrar) (b) Helen I. Pickel (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 10
year 1944 hour 12 minute 500 M.
21. I hereby certify that I attended the deceased from Oct 8, 1944, 19 , to Oct 10, 1944
that I last saw him alive on Oct 10 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture of Skull	2 days
Due to Accident	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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) Accident
(b) Date of occurrence Oct 8, 1944
(c) Where did injury occur? Hiawatha (City or town) Brown (County) Kansas (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Name (Specify type of place)
While at work? (e) Means of injury

23. Signature (M.D. or other) D.O.
Address 823 Faraon Date signed 10-10-44

1511

(Licensed Embalmer's Statement on Reverse Side)

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address St Joseph Mo

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

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N O U

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1017

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Charles E. Patton
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex m | 5. Color or race w | 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 10 (Day) 1868 (Year)

8. AGE: Years 60 | Months 7 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 10
year 1944 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Skull — Duration 2 days

Due to accident — Fell from ladder while

Due to fixing sky light

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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) Accident
(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?
Home (Specify type of place)
While at work? (e) Means of injury Fall

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

33740