

**FILED OCT 24 1944**

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

Primary Registration District No. 2000

49  
26

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

1. PLACE OF DEATH:

(c) County GREENE

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

(c) Name of hospital or institution: 534 State  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community 17 years  
years, months or days

3. (a) PRINT FULL NAME Frances Patterson

3. (b) If veteran, name war No

3. (c) Social Security No. No

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

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

7. Birth date of deceased March 10, 1854  
(Month) (Day) (Year)

8. AGE: Years 90 Months 7 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Home

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

MOTHER FATHER { 12. Name W.H. Schmalhorst

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Harry Brooksbanks

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 10/13/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Conway, Mo.

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

(b) Address Springfield, Mo.

19. (a) 10-11-44 (b) O. W. Standley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 29

(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 534 State  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11  
year 1944 hour 2 minute 55 a.m.

21. I hereby certify that I attended the deceased from Jan. 1940 to 10-11 1944  
that I last saw her alive on 10-10 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis  
General

Due to Rupture head of  
Cyst

Due to Thrombosis of  
mesenteric artery

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

Duration \_\_\_\_\_

Major findings: no

Of operations 2/1/11

Of autopsy see above

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 0

23. Signature [Signature] (M. D. or other) Mo

Address Springfield Mo Date signed 10-11-44

001 30 1947

---

---

**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.....

*Walter E. Hamilton*

Licensed Embalmer No. *3808*

P. O. Address *Springfield Mo.*

**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.**

*f*