

FILED JAN 12 1945

Registration District No. 267

Primary Registration District No. 5900

State File No.

Registrar's No. 67

1. PLACE OF DEATH

(a) County Missouri
(b) City or town Rural Proggadocia Twp
(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 None
(Specify whether years, months or days)
In this community 4 yrs

3. (a) PRINT FULL NAME

James Patten

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

4. Sex M 5. Color or race Ed.
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 unknown
(Month) (Day) (Year)

8. AGE: Years abt 55 Months Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business —

MOTHER FATHER { 12. Name DK
13. Birthplace DK (City, town, or county) (State or foreign country) 15
14. Maiden name DK
15. Birthplace DK (City, town, or county) (State or foreign country) 9

16. (a) Informant Will Braun

(b) Address Proggadocia Mo 64153

17. (a) Burial (b) Date thereof 11-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deering Mo

18. (c) Signature of funeral director Steele Mo

(b) Address 12-18-19th St Johnson Dept

19. (a) 12-18-19th St Johnson Dept (b) (Date received local registrar)
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Missouri
(c) City or town Rural Proggadocia Twp
(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 —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1944 hour — minute A.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 Foud dead in bed
Cause of Death unknown
Due to as there was no doctor

Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings: 200
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) —
(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? —

(Specify type of place) (e) Means of injury 3

23. Signature Est Kelley (M. D. or other) —
Address Hast. Mo Date signed 11-20-44

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

17-44-291

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.