S. No. 2
M—8-43
v. 5-17-39
X37823

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. 8113

FILED MAR 16 1945

Registration District No. 1518

Primary Registration District No. 1003

Registrar's No. 2165

1. PLACE OF DEATH:

(a) County: St Louis

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

(c) Name of hospital or institution: Homer Phillips Hospital (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: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 000

(c) City or town: St Louis (If outside city or town limits, write "RURAL") 1

(d) Street No.: 6111 Pennsylvania (If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME: Mattie Patterson

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Female

5. Color or race: Col

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: Aug (Month) 12 (Day) 1896 (Year)

8. AGE: Years 48 | Months 6 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Nurse Attendant

11. Industry or business: Homer Phillips Hospital

MOTHER FATHER

12. Name: Clarence Patterson

13. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)

14. Maiden name: Pauline Chatman

15. Birthplace: St. Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Ada Russell

(b) Address: 2133 Chestnut St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-7-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Washington Park

18. (a) Signature of funeral director: J. H. Randle & Son

(b) Address: 3133 Bell ave

19. (a) MAR 6 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March Day: 2nd year: 1945 hour: 1 minute: 8 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: Myocarditis Chronic Hypertrophy

Due to: Myocarditis Chronic Hypertrophy

Due to: 131

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ____ Of autopsy ____

Duration

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)

While at work? (e) Means of injury

23. Signature: Alfred Berry (M.D. or other)

Address: Clayton Mo Date signed: 3/5/45

(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: J. J. Watson

Licensed Embalmer No. 2698

P. O. Address: 2769 Shoutean

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.