

**FILED NOV 28 1945** STANDARD CERTIFICATE OF DEATH

State File No. **37392**

Registration District No. **141**

Primary Registration District No. **3025**

Registrar's No. **117**

**1. PLACE OF DEATH:**

(a) County **Howell**  
(b) City or town **West Plains**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**

(If not in hospital or institution, write street number or location)

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

In this community.....  
years, months or days

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

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

4. Sex **73** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **W, W, W**

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

7. Birth date of deceased **12 25 1874**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **9** Days **16** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **Jack Stetson**  
13. Birthplace **Ga 1**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Rachel Hale**  
15. Birthplace **Ga 1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Lavenia Taylor**  
(b) Address **9500 Pace Ave, Los Angeles, Calif**

17. (a) **8** (b) Date thereof **10 18 45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sadie Brown**

18. (a) Signature of funeral director **Robertson's**

(b) Address **West Plains, Mo.**

19. (a) **11-6-1945** (b) **Kludy Harrison**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Howell**  
(c) City or town **West Plains** 41  
(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.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **10** day **11**  
year **1945** hour **10** minute **40** A.M.

21. I hereby certify that I attended the deceased from **10-9-1945** to **10-11-1945**  
that I last saw **her** alive on **10-9-1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Chronic arteriosclerosis myocarditis  
chronic nephritis**

Due to.....  
Due to.....

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?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature **E. L. Barber** (M. D. or other) **MD**  
Address **West Plains, Mo** Date signed **10-20-45**

**1517** (Licensed Embalmer's Statement on Reverse Side) **Bohres**

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

RECEIVED

District Health Officer No. 5,

District File Number 1145-425-

Date Filed 11-14-45.

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

Paige A. Robertson

Registered Apprentice No. 3435-

working under my personal supervision.

Signed

Paige A. Robertson

Licensed Embalmer No. 3435

P. O. Address. West Plains, 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.