

No. 2  
5-43  
17-39  
X3687

State File No.

FILED JAN 5 1946  
Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 91

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town WASHINGTON, Twnshp. "Rural"  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
116<sup>th</sup> St. + 71 Highway.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 35 YEARS. (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME JERRY M. PATE

3. (b) If veteran,  name war \_\_\_\_\_

3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife SARAH E. PATE

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

7. Birth date of deceased APRIL 22 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84	8	1	hr. _____ min.
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9. Birthplace BATES Co. Mo. O  
(City, town, or county) (State or foreign country)

10. Usual occupation RESTAURANT TOURIST CAMP PROP.

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

12. Name JEREMIAH PATE

13. Birthplace Ky. I  
(City, town, or county) (State or foreign country)

14. Maiden name ARTEMISSIA MARCUM

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

16. (a) Informant MRS LEE R. MOONEY

(b) Address 3157 PENN., K.C., MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Dec. 26 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation FALLEST HILL, K.C., MO.

18. (a) Signature of funeral director C. N. George

(b) Address Seardown, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town HICKMAN MILLS, "RURAL"  
(If outside city or town limits, write "RURAL")

(d) Street No. 116<sup>th</sup> + 71 Highway.  
(If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23  
year 1945 hour 7 minute 0 A. M.

21. I hereby certify that I attended the deceased from 28 NOV 1945  
to 23 DEC 1945  
that I last saw him alive on 23 DEC 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 48 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arterial Sclerosis - General.  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations gcta

Of autopsy \_\_\_\_\_

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 A. M. Myers (M. D. or other) M.D.  
Address 1025 North Bluff Date signed \_\_\_\_\_

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

1152

12/31

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**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..... *A. K. George* .....

....., Licensed Embalmer No. *3645* .....

P. O. Address *Grandview, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 91

Registration District No. 154

Primary Registration District No. 5575-

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

Jerry M. Patz

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 wid

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

7. Birth date of deceased April 22, 1890  
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12/31/45 (b) Dr. Annie B. Hodges  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

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) \_\_\_\_\_  
(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 \_\_\_\_\_

Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

41431