

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37128**

FILED DEC 4 1946

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
(Specify whether
In this community **35 years**
years, months or days)

3. (a) PRINT FULL NAME **Joe Patton**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
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 **Oct. 21 1883**
(Month) (Day) (Year)

8. AGE: Years **63** Months **6** Days **16**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Unknown**

11. Industry or business _____

12. Name **Frank Patton**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Kate Bowlan**

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

16. (a) Informant **Record Clerk**

(b) Address **K.C. General Hosp.**

17. (a) **Burial** (b) Date thereof **11-18-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Calvary: K.C. Kan.**

18. (a) Signature of funeral director **Weilert Funeral Home**

(b) Address **Kansas City, Mo.**

19. (a) **11-18-46** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **547 1/2 Main**
(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 **7**
year **1946** hour **8** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Nov. 3 1946** to **Nov. 7 1946**;
that I last saw him alive on **Nov. 7 1946**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident**
Duration _____

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy **None**

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? **A**

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

23. Signature **Wm W. Hart** (M.D. or other) **MD**

Address **Med. Dir. Gen'l Hosp.** Date signed **11-7-46**

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

MOTHER FATHER

Dr. Men. 11/11/11

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.....

Blaine E. Wailut

Licensed Embalmer No.....

4075

P. O. Address.....

K.C. 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.