DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1946

Registration District No. 371

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6676

State File No. 42033

Registrar's No. 3466

1. PLACE OF DEATH:
(a) County: St Louis Mo
(b) City or town: Koch (If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: Koch Hospital (If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution: 104 Days (Specify whether years, months or days)
In this community: 104 Days

2. USUAL RESIDENCE OF DEACESED:
(a) State: Missouri (b) County: St Louis 00 11
(c) City or town: St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 3113 Newstead (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country: —

3. (a) PRINT FULL NAME: Robert Lee Patterson
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: 499-26-9759

4. Sex: Male 2
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Separated
6. (b) Name of husband or wife: June Patterson
6. (c) Age of husband or wife if alive: ? years
7. Birth date of deceased: 5 (Month) 15 (Day) 26 (Year)

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

9. Birthplace: Colts (City, town, or county), Ark. (State or foreign country) 1
10. Usual occupation: Nil
11. Industry or business: —
12. Name (Father): Dennis Patterson 1
13. Birthplace (Father): Colts (City, town, or county), Ark. (State or foreign country)
14. Maiden name (Mother): Tempie Williamson
15. Birthplace (Mother): Colts (City, town, or county), Ark. (State or foreign country) 1
16. (a) Informant: Hospital Records
(b) Address: Koch Hosp. Koch, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Forrest City Cem
18. (a) Signature of funeral director: D J Walker
(b) Address: 2749 Chouteau
19. (a) 12-9-46 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 5 year 46 hour 12 minute 30 A.M.
21. I hereby certify that I attended the deceased from 8-23, 1946 to 12-5, 1946 and that I last saw him alive on 12-5, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration: About One Year?
Due to:
Due to: 13b
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? (Specify type of place) 0
While at work? (e) Means of injury:

23. Signature: Bernard Friedman (M. D. or other) M.D.
Address: Koch Hosp. Koch, Mo. Date signed: 12-5-46

(Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chour

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.