

No. 2
5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **11379**
3006
Registrar's No.

Registration District No. **318** Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis Mo.
 (b) City or town St. Louis Mo.
 (c) Name of hospital or institution Barnes Hospital, 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 days
 In this community lifetime
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois 94
 (c) City or town Bonne Terre Mo
 (d) Street No. 311 Avon Pl.
 (e) Citizen of foreign country? No
 If yes, name country No

3. (a) PRINT FULL NAME Ollie Isabelle Patt
 3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____
 4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Clifford E. Patt
 6. (c) Age of husband or wife if alive 21 years
 7. Birth date of deceased Jan 13 1930
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1947 hour 7 minute 40 A.M.
 21. I hereby certify that I attended the deceased from March 5, 1947, to March 19, 1947;
 that I last saw her alive on March 19, 1947;
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>17</u>	<u>2</u>	<u>6</u>	hr. _____ min. <u>0</u>

Immediate cause of death RESPIRATORY FAILURE
 Due to ACUTE LYMPHATIC LEUKEMIA
 Other conditions AK
 Major findings:
 Of operations _____
 Of autopsy _____
 Duration _____
 Underline the cause to which death should be charged statistically.

MOTHER {
FATHER {
 9. Birthplace Bonne Terre Mo.
 10. Usual occupation factory worker
 11. Industry or business Shirt factory
 12. Name Monte White
 13. Birthplace Palmer Mo
 14. Maiden name Frances Anderson
 15. Birthplace Cuba Mo
 16. (a) Informant Mrs. Frances White Holke
 (b) Address 311 Avon Pl. Bonne Terre Mo
 17. (a) Burial (b) Date thereof 3-23-47
 (c) Place: burial or cremation St. Francis Memorial Park
 18. (a) Signature of funeral director Sparks Funeral Home
 (b) Address 390 Taylor Flat River Mo
 19. (a) MAR 21 1947 (b) J. F. Brudnick
 (Date received local registrar) (Registrar's signature)

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) _____
 (c) Means of injury 0
 23. Signature F. R. Bradley (M. D. or other) _____
 Address Barnes Hospital, Date signed 3/19/47

APR 21 1987

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 Everett Sparks

Licensed Embalmer No. 1287

P. O. Address Flat River 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. April
Registrar's No. Boyle

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... ST. LOUIS
(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..... Ollie J. Patt

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

3. (c) Social Security No.....

4. Sex..... F

5. Color or race..... w

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased..... Jan 13
(Month) (Day) (Year)

8. AGE: Years Months Days Unless than one day
17 2 2 mo
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) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 3-21-1947 (b) J. F. Braddock
(Date received local registrar) (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 CERTIFICATE

20. DATE OF DEATH: Month..... March 19..... 1947
year..... hour..... minute..... M.

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

Due to.....

Due to.....

Other conditions.....
(include pregnancy within 3 months of death)

Major findings:
Of operations.....

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)

(c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

14.

11379