

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24866**
Registrar's No. **81**

Registration District No. **277** Primary Registration District No. **5787**

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

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston-Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 Miles South City limits
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 65 years
years, months or days)

3. (a) PRINT FULL NAME Benjamin L. Patrick
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Annie Elizabeth Patrick Decd
6. (c) Age of husband or wife if Decd years
7. Birth date of deceased December 9, 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 0
If less than one day hr. _____ min.

9. Birthplace Near Nashville, Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Retired

MOTHER FATHER

12. Name John Patrick

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

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Patrick

(b) Address Bertrand, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/47
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove-Charleston, Mo

18. (a) Signature of funeral director John J. Thummele Jr
(b) Address Charleston, Missouri

19. (a) 8-6-47 (Date received local registrar) (b) Mrs. John Bondurant (Registrar's signature) 1947

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
(c) City or town Bertrand
(If outside city or town limits, write "RURAL")
(d) Street No. none
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1947 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from Apr 22 1947 to July 9 1947
that I last saw him alive on July 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Due to Arterio-Sclerosis

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None
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? _____

While at work? _____ (Specify type of place) (e) Means of injury Stroke
Signature Ges W Whitaker (M. D. or other) J
Address East Prairie Mo Date signed 7/11/47

RECEIVED

District Health Office No. 2,

- District File Number 842-1066

Date Filed 8-11-47

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

John F. Nisselle Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.