

S. No. 2  
 DM-5-43  
 v. 5-17-39  
 I X36571

FILED SEP 23 1947

Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **3914**

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

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: **St Joseph Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: **13 hours** (Specify whether in this community  years, months or days) **13 hrs.**

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo** (b) County **Cass**  
 (c) City or town **Garden City**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **No Number** (If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country

3. (a) PRINT FULL NAME **Robert H Patton**  
 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 **Deceased unk.** 6. (c) Age of husband or wife if alive **years**  
 7. Birth date of deceased **Sept 20 - 1874**  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Sept** day **12** year **1947** hour **11** minute **20 P.** M.  
 21. I hereby certify that I attended the deceased from **Sept 17** to **Sept 17** 19**47**, that I last saw him alive on **Sept 17** 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia of Gall Bladder**  
 Duration  
 Due to  
 Due to

8. AGE: Years Months Days If less than one day  
**72 11 22** hr. min.

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

10. Usual occupation **Barber**

11. Industry or business

12. Name **William Patton**

13. Birthplace **No Record** (City, town, or county) (State or foreign country)

14. Maiden name **S. W. A. N.**

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

16. (a) Informant **Earl Patton**  
 (b) Address **3419 Olive K.S. Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 19 1947** (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Garden City Cemetery**

18. (a) Signature of funeral director **Harrison Bow**  
 (b) Address **Harrisonville Mo.**

19. (a) **9-13-47** (b) **Thereldine Helmer** (Date received local registrar) (Registrar's signature)

Other conditions **Acute renal Fibrosclerosis**  
 (Include pregnancy within 3 months of death)

Major findings: **1270**  
 Of operations

Of autopsy **Pneumonia Gall Bladder**

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 **George W. Gullick** (M. D. or other)  
 Address **4000 Bell St. K.C. Mo.** Date signed **9/13/47**

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

---

---

**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

*Floyd Atkinson*

Licensed Embalmer No.

*3420*

P. O. Address

*Harrisonville*

**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.**