

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35111
Registrar's No. 19

Registration District No. 23 Primary Registration District No. 4346

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Montgomery
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 12 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Xenia Patterson Sturgeon
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 W
6. (b) Name of husband or wife Herrion H. Sturgeon 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 23rd 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 X 22 hr. min.

9. Birthplace St Louis Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
12. Name Elisha W. Patterson
13. Birthplace St Louis Co Mo (City, town, or county) (State or foreign country)
14. Maiden name Melissa Fugate
15. Birthplace St Louis Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs C.C. Frank
(b) Address Montgomery City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation Middletown Cemetery Mo

18. (a) Signature of funeral director C. W. Hopkins
(b) Address Montgomery City Mo
19. (a) 10-18-47 (Date received local registrar) (b) William J. Spore (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town Montgomery (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 CERTIFICATION

20. DATE OF DEATH: Month Oct day 15 th year 1947 hour 6 minute P M.

21. I hereby certify that I attended the deceased from August 25, 1942, to Oct. 15, 1947; that I last saw him alive on Oct. 15, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage - lph. with Right Hemiplegia
Due to chronic Myocarditis
Due to chronic nephritis
Other conditions senility
(include pregnancy within 3 months of death)

Duration
8 days
10 years
10 years
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings, Of operations none
Of autopsy none

22. If death was due to external causes, fill in the following:
(c) Accident, suicide, or homicide (specify) no
(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 E. T. Andersen, M.D. (M. D. or other) 10/18/47
Address Montgomery City, Mo Date signed 10/18/47

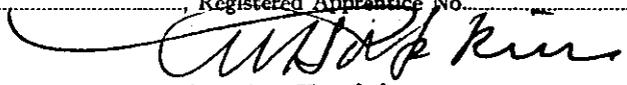
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

NOV 10 1947

RECEIVED
District Health Officer No. 9,
District File Number
NOV 7 1947
Date Filed

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, on 15 th day
of Oct 1947
working under my personal supervision.

Registered Apprentice No. _____

Signed C. W. Hopkins

Licensed Embalmer No. 1487

P. O. Address Montgomery City 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.