

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18416

State File No.

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Wash. Twp. 27</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> <u>39</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>State Hospital #32</u>		d. STREET ADDRESS (If rural, give location) <u>Unknown</u> <u>4</u> <u>1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edith</u> b. (Middle) _____ c. (Last) <u>Patrum</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 17 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 4, 1877</u>
9. AGE (In years last birthday) <u>71</u>		<input type="checkbox"/> UNDER 1 YEAR Months _____ Days _____	<input type="checkbox"/> UNDER 1 Wk. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Fredrick Bodawsky</u>	13b. MOTHER'S MAIDEN NAME <u>Johanna Walkdor</u>	14. NAME OF HUSBAND OR WIFE <u>Patrum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>(None)</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records State Hosp #3 Nevada Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praecox</u>	
19a. DATE OF OPERATION <u>(none)</u>		19b. MAJOR FINDINGS OF OPERATION _____	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 1</u> , 19 <u>43</u> , to <u>May 17</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-16-</u> , 19 <u>49</u> and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. H. Hall M.D.</u> (Degree or title)		23b. ADDRESS <u>Nevada Mo</u>	23c. DATE SIGNED <u>5-17-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 18-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Springfield Mo</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo</u>
DATE REC'D BY LOCAL REG. <u>May 24, 49</u>	REGISTRAR'S SIGNATURE <u>Kathryn H. Vance</u>	331	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman H. F. Schuyler, Springfield Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 7;

District File Number 4-49-575

Date Filed 5-23-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Marl C. Eubank

Signed _____
Student Embalmer

Licensed Embalmer No. 2656

P. O. Address Quincy, 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.