

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7171

BIRTH NO. _____ REG. DIST. NO. 917 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1348

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Jefferson Barracks township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri	
c. LENGTH OF STAY (In this place) 83 days		d. STREET ADDRESS (If rural, give location) Laclede Hotel, 6th & Chestnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vet. Adm. Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) R.	c. (Last) McFATRIDGE	4. DATE OF DEATH (Month) (Day) (Year) February 7 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH February 5, 1898	9. AGE (In years last birthday) 52	10. MONTHS 1	11. DAYS 1	12. HOURS 1	13. MIN. 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Little Rock, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Archie McPatridge	13b. MOTHER'S MAIDEN NAME Margaret O'Reilly	14. NAME OF HUSBAND OR WIFE Marian McPatridge
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. 498-10-9839	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INFARCTION OF LUNG (RT)		Years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) RHEUMATIC HEART DISEASE DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4/6X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **11-17-49**, 19**49**, to **2-7-** 19**50**, and that death occurred at **1:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L.E. Stowell Chf. Prof. Svcs.	23b. ADDRESS Vet. Adm. Hosp. Jeff. Brks, Mo.	23c. DATE SIGNED 2-8-50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY National	24d. LOCATION (City, town, or county) (State) Jeff. Brks, Mo.
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DATE REC'D BY LOCAL REG. 2-8-50	REGISTRAR'S SIGNATURE Herbert R. ...	25. FUNERAL DIRECTOR'S SIGNATURE HOFFMEISTER U&L Co., St. Louis, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Harry J. Schumacher
.....
Licensed Embalmer No. *2679*

Signed.....
Student Embalmer

P. O. Address *7814 F. Broadway*

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.