

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25146  
6304

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 State File No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis 2259

d. FULL NAME OF HOSPITAL OR INSTITUTION 1728 O'Fallon St

e. STREET ADDRESS (If rural, give location) 1728 O'Fallon St

3. NAME OF DECEASED  
a. (First) Mattie b. (Middle) \_\_\_\_\_ c. (Last) Patton

4. DATE OF DEATH (Month) (Day) (Year) 7-21-50

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH March 6, 1879

9. AGE (In years last birthday) 71 # UNDER 1 YEAR Months \_\_\_\_\_ # UNDER 1 YEAR Days \_\_\_\_\_ # UNDER 1 YEAR Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) Georgia

12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME William Dave

13b. MOTHER'S MAIDEN NAME Dannie Scott

14. NAME OF HUSBAND OR WIFE G.E. Patton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rosie Lee Moore, 1728 O'Fallon

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Bilateral Co of Breasts with metastases  
ANTECEDENT CAUSES \_\_\_\_\_ DUE TO (b) \_\_\_\_\_ DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
about 6 mo.

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR 170X

22. I hereby certify that I attended the deceased from July 2, 1950, to July 22, 1950 that I last saw the deceased alive on July 22, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chas. R. Frazer, Jr. M.D.

23b. ADDRESS 1421 Kansas East St. Douglass

23c. DATE SIGNED July 23, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 7-24-50

24c. NAME OF CEMETERY OR CREMATORY 1

24d. LOCATION (City, town, or county) (State) Forrest City, Ark.

DATE REC'D BY LOCAL REG. JUL 24 1950

REGISTRAR'S SIGNATURE J-B Fosater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G. Wade Granberry 4202 Finney

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.

Signed.....  
Student Embalmer

Student Embalmer No.....  
Signed *John R. Cunningham*

Licensed Embalmer No. *4476*

P. O. Address *4107 Terway*

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.