

FILED SEP 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26348**

BIRTH NO.		REG. DIST. NO. 42	PRIMARY REG. DIST. NO. 1000	Registrar's No. 960
1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Andrew		
b. CITY OR TOWN St. Joseph	c. LENGTH OF STAY (in this place township) 2 weeks	c. CITY OR TOWN SAVANNAH	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		f. STREET ADDRESS (If rural, give location) 403 W. Chestnut		
3. NAME OF DECEASED (Type or Print) a. (First) Ernest		b. (Middle) patterson	c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) 9-5-1954		5. SEX male 6. COLOR OR RACE white		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 6-26-1886		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) veterinarian		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Holt Co. Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William H. Patterson		
13b. MOTHER'S MAIDEN NAME Eliza Jane Cobb		14. NAME OF HUSBAND OR WIFE Imable Patterson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Imable Patterson ADDRESS 403 W. Chestnut
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Stenosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years 5 years.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. 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 8-19, 1954 , to 9-5, 1954 , that I last saw the deceased alive on 9-4, 1954 , and that death occurred at 7 A.M. , from the causes and on the date stated above.				
23a. SIGNATURE W. C. Baile (Degree or title)		23b. ADDRESS M.D. 9706 Francis, St Joseph, Mo		23c. DATE SIGNED 9-6-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-7-1954		24c. NAME OF CEMETERY OR CREMATORY SAVANNAH
24d. LOCATION (City, town, or county) (State) SAVANNAH MO		25. FUNERAL DIRECTOR'S SIGNATURE Allison Breit ADDRESS Funeral Home SAVANNAH MO		
DATE REC'D BY LOCAL REG. Sept 8, 1954		REGISTRAR'S SIGNATURE Kathleen M. Allison 485		

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

APR 12 1955

VS
AUG 30 1960

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..

Student.....
Signature of Student Embalmer

Signed..... *E. C. Breit*

Licensed Embalmer No. *2653*

P. O. Address *Savannah*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.