

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 17 8 8 0  
STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 195 Primary Registration District No. 5706 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <b>McDonald</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>McDonald</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Anderson (R)</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Anderson RT 3</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in lb <b>3 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>Deer</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DANIEL SANDERS PATTON</b> First Middle Last			4. DATE OF DEATH <b>3-31-1957</b> Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-1874</b>
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PEARIDGE, ARK</b>	11. BIRTHPLACE (City and state or country) <b>W.S</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>ROBT PATTON</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET REYNOLDS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ETTA SPENCER PINEUBHMO</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from _____, to _____ and last saw her <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. M. Humphrey, Coroner Noel</b> (Degree or title)		22b. ADDRESS <b>Mo.</b>	
22c. DATE SIGNED <b>4-1-57</b>		23. NAME OF CEMETERY OR CREMATORY <b>Elm Springs Ark</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>4-2-1957</b>	
23c. LOCATION (City, town, or county) <b>Elm Springs, Ark</b>		(State) _____	
24. FUNERAL DIRECTOR <b>R. M. Humphrey</b> ADDRESS <b>Parsons, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-30-57</b>	
26. REGISTRAR'S SIGNATURE <b>Mayme Humphrey</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

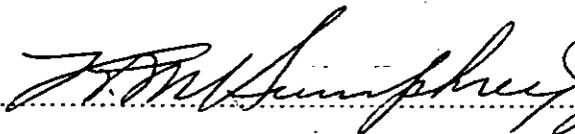
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300  
1-56

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 

Licensed Embalmer No. 47

P. O. Address 

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.