

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36058
STATE FILE NUMBER
4510

FILED OCT 16 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4510

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Childrens Mercy Hospital</u> <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u> </u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>St. Louis</u> 2198	
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>Childrens Mercy Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>19 South Boyle</u>	
Length of stay in 1b <u>29 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Patricia Jean Patterson</u>			4. DATE OF DEATH Month Day Year <u>9 - 27 - 57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-57</u>
9. AGE (In years last birthday) <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	11. BIRTHPLACE (City and state or country) <u>Iberia, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
13a. FATHER'S NAME <u>Lowell Patterson</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Wood</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Barbara Wood Patterson St. Louis, Mo</u> Address <u>19 South Boyle</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Purulent meningococcal</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0824</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 <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 <u>8-30-57</u> to <u>9/27/57</u> and last saw her alive on <u>9/27/57</u> Death occurred at <u>3.15 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wayne Hart MD</u>		22b. ADDRESS <u>K. C. Hwy 1710 Independence Ave</u>	
22c. DATE SIGNED <u>9-27-57</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT. 27 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DIXON</u>		23d. LOCATION (City, town, or county) (State). <u>MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS</u>		ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>9-28-57</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Wayne Hart

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.

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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 *Basil J. Honey*,
.....

Licensed Embalmer No. *4724*,
P. O. Address *Ke, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.