

Health, Welfare  
Public Service

FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005766  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 405

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Elizabeth's Nursing Home</u>		Length of stay in lb <u>40 yrs</u>	d. STREET ADDRESS <u>5024 E. 54 St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>PATTERSON</u> Last <u>PATTERSON</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>-24</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-18-1892</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook Paper Co</u>	11. BIRTHPLACE (City and state or country) <u>Coal Sale, Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>maude</u>		14. NAME OF HUSBAND OR WIFE <u>Elizabeth</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-07-9267</u>	17. INFORMANT <u>Trouman Patterson</u>		Address <u>6210 E. 64th K.C. Mo</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>Bilateral Pneumonitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Atherosclerotic Cerebral Vascular Disease</u>	DUE TO (c) <u>years</u>			<u>334 X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerotic Coronary Artery Disease</u>					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 <u>-</u> Month, Day, Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>						
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>6-21-57</u> to <u>1-24-58</u> and last saw her alive on <u>1-23-58</u> Death occurred at <u>4:25 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Robert L. Ward, M.D.</u>			22b. ADDRESS <u>4126 St. John</u>		22c. DATE SIGNED <u>1-25-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-27-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>			
24. FUNERAL DIRECTOR <u>C.F. Blackburn &amp; Son Inc. K.C. Mo</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-25-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Robert L. Ward

All diseases in Part I must be causally related.

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 *W C Prime* .....

Licensed Embalmer No. *4879* .....

P. O. Address *K.C. 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.