

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013445  
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 97

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b> <u>0143</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Callaway Mem. Hosp</b>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS <b>1203 Amherst St.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ewell</b> Middle <b>Rone</b> Last <b>Patterson</b>			4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Male</b> <u>0</u>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1899</b>	9. AGE (In years last birthday) <b>58</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning Pt.</b>	11. BIRTHPLACE (City and state or country) <b>Columbia Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>James Patterson</b>		13b. MOTHER'S MAIDEN NAME <b>Ada Jones</b>	14. NAME OF HUSBAND OR WIFE <b>Maude L. Patterson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Address <b>Mrs. Maude Patterson Fulton Mo.</b>			
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>Cardiac Decompensation</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Myocardial Degeneration</b>		DUE TO (c) <b>4222</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <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>Oct. 1957</u> to <u>Death</u> and last saw her alive on <u>4-20-58</u> Death occurred at <u>9:30 PM</u> in on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>John J. Brown MD</b>			22b. ADDRESS <b>Fulton Mo</b>		22c. DATE SIGNED <b>4-25-58</b>	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 22, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Callaway Mem. Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Fulton, Missouri.</b>		
24. FUNERAL DIRECTOR <b>Maupin Funeral Home</b>		ADDRESS <b>Fulton Mo</b>	25. DATE RECD. BY LOCAL REG. <b>April 26, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

