

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034579

STATE FILE NUMBER

FILED OCT 3 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9000

S. 300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, HOSPITAL OR INSTITUTION) <b>St. Louis Children's Hospital</b> Length of stay in lb <b>14 days</b>		d. STREET ADDRESS (If outside, give location) <b>3758 Penrose Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Judith</b> Middle <b>Ann</b> Last <b>Patterson</b>			4. DATE OF DEATH Month <b>9-</b> Day <b>16-</b> Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-57</b>
9. AGE (In years last birthday) <b>1</b>		IF UNDER 1 YEAR Months <b>5</b> Days	IF UNDER 24 HRS. Hours <b></b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Oliver A. Patterson</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Ruth Parrott</b>		14. NAME OF HUSBAND OR WIFE <b>Single</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 Address <b>Alice Trowbridge, 500 S. Kingshighway</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>Congenital Heart Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } <del>DECEASED</del> (b) <b>Longitudinal Sinus Thrombosis</b> DUE TO (c) <b>1) Tricuspid Atresia 2) Pulmonary stenosis 3) Inter Atrial Septal Defect 4) Inter Ventricular Septal Defect 5) Cardiomegaly 6) Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>754.2</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>754.2</b>	
20c. TIME OF INJURY Hour <b></b> Month, Day, Year a.m. <b></b> p.m. <b></b>			
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 <b>9-2-58</b> to <b>9-16-58</b> and last saw her alive on <b>9-16-58</b> Death occurred at <b>11:35 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. N. Middlekamp M.D.</b>		22b. ADDRESS <b>500 S. Kingshighway</b>	22c. DATE SIGNED <b>SEP 17 '58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-17-58</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Mountain View, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 17 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>

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 *J. W. Bantley* .....

Licensed Embalmer No. *3653* .....

P. O. Address *St. Louis 8* .....

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.