Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001730
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY: Jasper b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Joplin — Inside Limits: Yes [X] No [ ] c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Freeman Hospital — Length of stay in Ib: 5 days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: Jasper c. CITY OR TOWN: Webb City c 492 — Inside Limits: Yes [X] No [ ] d. STREET ADDRESS (If outside, give location): 222 W. 2nd. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First: Nellie	Middle: Guinn	Last: Patton	4. DATE OF DEATH: Month Day Year — January 24, 1959
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH: 10-15-1887	9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Altona Kansas	12. CITIZEN OF WHAT COUNTRY?: U.S.A.	
13a. FATHER'S NAME: Thomas Guinn	13b. MOTHER'S MAIDEN NAME: Alice Rhupert	14. NAME OF HUSBAND OR WIFE: Fred Patton Deceased		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 491-07-8188D	17. INFORMANT: Mrs Donna Wallace Address: Carterville Mo.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Circulatory Failure, Acute — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Pulmonary Infarction — 40 hours

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Lobar Pneumonia

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1-10-50, to 1-24-59 and last saw her alive on 1-24-59. Death occurred at 11:50 AM. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Jim Ferguson (Degree or title) MD

22b. ADDRESS: Webb City Mo.

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1-27-1959	23c. NAME OF CEMETERY OR CREMATORY: Mount Hope	23d. LOCATION (City, town, or county) (State): Webb City Missouri
24. FUNERAL DIRECTOR ADDRESS: Hedge-Lewis Funeral Home, Webb City Mo.		25. DATE RECD. BY LOCAL REG.: 1-29-1959	26. REGISTRAR'S SIGNATURE: Dove Merriam

(Licensed Embalmer's Statement on Reverse Side)

300 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 24 1959

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 Richard Gray Lewis

Licensed Embalmer No. 4405

P. O. Address Webb City 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.