

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002148
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 1-59

300
1-57

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Miller	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Tuscumbia		c. CITY OR TOWN Iberia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Humphreys HOSPITAL		d. STREET ADDRESS (If outside, give location) 066 o Richwoods Twp	
3. NAME OF DECEASED (Type or print) First Middle Last William Wesley Patterson		4. DATE OF DEATH Month Day Year Jan 15, 1959	
5. SEX Male o	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1895
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (City and state or country) Ulman Mo o
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Patterson	
13b. MOTHER'S MAIDEN NAME Camilla Nixdorf		14. NAME OF HUSBAND OR WIFE Cora Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Cora Patterson Iberia, Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Chronic Bronchiectasis</i> DUE TO (c) <i>Bronchial asthma</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> o
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>1945</u> to <u>Jan 15, 1959</u> and last saw her/him alive on <u>Jan. 15, 1959</u> Death occurred at <u>9:25 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>W.M. Gould D.O. 2</i>		22b. ADDRESS <i>Iberia Mo</i>	
22c. DATE SIGNED <u>1/16/59</u>			
23a. BURIAL, CREMATION, (Specify) <u>Burial</u>		23b. DATE <u>1/18/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Point</u>		23d. LOCATION (City, town, or county) <u>Iberia, Mo</u> (State)	
24. FUNERAL DIRECTOR <u>Walter P. Wedge</u> ADDRESS <u>Hedges Funeral Homes Iberia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-19-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. D. E. Kallenbach</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Decay, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JAN 29 1959

Miller County
Health Department

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 *Walter P. Hedges*

Licensed Embalmer No. *4265*
P. O. Address *Yonkers, N.Y.*

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.