THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005195
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 219

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Burge Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1203 Robberson — Reside on Farm: Yes [ ] No [XX]

3. NAME OF DECEASED (Type or print): First SARAH Middle J. Last PATTERSON
4. DATE OF DEATH: Month February Day 28 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 20 Dec. 1886
9. AGE (In years last birthday): 72 — 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): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: YWCA
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: J.T.Bay
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Walter Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Hospital Records — 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): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Intracerebral bleeding - probable — 8 hours
DUE TO (c): Hypertensive - arteriosclerotic vascular disease — Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 330X
19. WAS AUTOPSY PERFORMED? YES [ ] 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 2-27-59, to 2/28/59 and last saw her alive on 2-27-59
Death occurred at 1:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carl R. Auner MD.
22b. ADDRESS: [redacted] Springfield, Missouri
22c. DATE SIGNED: Mar 2 '59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-3-59
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn
23d. LOCATION (City, town, or county) (State): Springfield, Missouri

24. FUNERAL DIRECTOR — ADDRESS: J.W.KLINGNER & CO. SPRINGFIELD, MO.
25. DATE RECD. BY LOCAL REG.: 3-4-59
26. REGISTRAR'S SIGNATURE: Effie G. Melton

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed .....

Signature of Student Embalmer

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Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.