

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024249

FILED VS. AUG 17 1959 042

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829

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Most of life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1719 St. Joseph Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fred Middle L. Last Patchin				4. DATE OF DEATH Month August Day 10, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1900	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Park Floral Co.		11. BIRTHPLACE (City and state or country) Albany, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Elwood Patchin			13b. MOTHER'S MAIDEN NAME Luella Greenwell		14. NAME OF HUSBAND OR WIFE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-10-7180		17. INFORMANT Address Mrs. W.C. Seidel St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic shock - Hemorrhage of cerebral vessels						INTERVAL BETWEEN ONSET AND DEATH 14 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Depressed skull fracture Temporo-parietal				14 hours		
	DUE TO (c) Being struck with chair during fight				14 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) Walter gunn asked him to stop cursing with chair						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Justifiable					
20c. TIME OF INJURY Hour 5 p.m. Month, Day, Year Aug 9 59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 719 St. Joe Ave St. Joseph Mo		20f. CITY, TOWN, OR LOCATION St. Joseph Buchanan Mo		
21. I attended the deceased from viewed body				and last saw her/him Aug 9 - 59			
Death occurred at 7:00 A.				m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) S.E. Meloney M.D., Coronary			22b. ADDRESS St. Joseph 8, Mo			22c. DATE SIGNED Aug 12 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 12, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.			
24. FUNERAL DIRECTOR Meierhoffer Fleeman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Aug. 14 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Standell		

DOCUMENT

BY AFFIDAVIT OF S.E. Meloney, Medical Certification

SEP 3 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Eric J. Murray

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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