

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024371

FILED VS JUL 24 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 193

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>			Length of stay in 1b <u>32 years</u>		c. CITY OR TOWN <u>Mexico</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Patterson</u> Last <u>Patterson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>St. Hospital No. 1, Fulton, Mo.</u> 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) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome due to Convulsive Disorder</u>					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 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <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. <input checked="" type="checkbox"/> Attended the deceased from <u>8-6-1926</u> to <u>7-20-1959</u> and last saw her <u>7-20-1959</u> alive on <u>7-20-1959</u> Death occurred at <u>1:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Erwin Leonhardt, MD</u> (Type name and title)				22b. ADDRESS <u>St. Hospital No. 1</u>		22c. DATE SIGNED <u>7-20-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <u>Mexico Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>ARNO (FUNERAL HOME MEXICO MO)</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 18 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 Cleo Arnsch

Licensed Embalmer No. 3569
P.O. Address Mexico

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.