

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024544

FILED VS AUG 4 1959

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 5295 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Clinton</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u> Length of stay in 1b <u>3 mos.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warren Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u> c. CITY OR TOWN <u>Osborn</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lilley</u> Middle <u>Sella</u> Last <u>Patten</u>			4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>Female</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>12-21-1876</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
13a. FATHER'S NAME <u>Jake E. Wills</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Scantling</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas C. Patten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Alice M. Mahley, Osborn, 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>Cerebral Apoplexy</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 Mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 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.		Month, Day, Year			
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. I attended the deceased from <u>April 15-9 July 28-31</u> and last saw her alive on <u>July 27-59</u> Death occurred at <u>7140 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. E. Summerfield, M.D.</u>			22b. ADDRESS <u>Plattsburg, Mo.</u>		22c. DATE SIGNED <u>July 28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-30-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stewartsville</u>		23d. LOCATION (City, town, or county) (State) <u>Stewartsville, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>W.E. Summerfield, Stewartsville, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-29-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mary W. Searee</u>

DOCUMENT

MEDICAL CERTIFICATION

BY APPOINTMENT OF Funeral Director

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

W. E. Summerfield

Licensed Embalmer No. 3007

Stewartville

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