

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025347

FILED VS JUL 27 1959 149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. **3368** STATE FILE NUMBER

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 34 yrs | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS 1105 Bales (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First ELIZA Middle CYNTHIA Last PATTERSON | | | 4. DATE OF DEATH Month 7 Day 8 Year 59 | | | |
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| 5. SEX Fe | 6. COLOR OR RACE Wh | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-29-84 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) Wheeling W. Va. | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME G.D. Havens | 13b. MOTHER'S MAIDEN NAME Sarah Groseclose | 14. NAME OF HUSBAND OR WIFE Daniel E. Patterson |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Mrs. Opal Flueckinger, 6020 Virginia |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Terminal pneumonia | | 24 hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Hypernephroma, left kidney, with metastasis to the left femur. | 11 months |
| DUE TO (c) _____ | | |
| 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 |

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| 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.) |
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| 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 |
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| 21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at 5:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. |
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|--------------------------------------|----------------------------------|--|-----------------------------------|
| 22a. SIGNATURE <i>[Signature]</i> | (Degree or title) M.D. | 22b. ADDRESS 4800 E. 24th Street | 22c. DATE SIGNED 7-9-59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-11-59 | 23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City Mo |
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| 24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, 166 Mo | 25. DATE RECD. BY LOCAL REG. 7-9-59 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **R.S. Long**

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 Alvin R. Harnsbeck

Licensed Embalmer No. 4159

P. O. Address Kansas

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.