IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1959

59–030140
STATE FILE NUMBER

Registration District No. 910 Primary Registration District No. 3058 Registrar's No. 148

1. PLACE OF DEATH
a. COUNTY: ST. CHARLES
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. CHARLES — Length of stay in 1b: 3 WKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. CHARLES NORSING HO — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: ST. LOUIS
c. CITY OR TOWN: RICHMOND HEIGHTS — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 7351 WISE AVE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MARY Middle JANE Last PATTERSON
4. DATE OF DEATH: Month AUGUST Day 25 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5/15/1869
9. AGE (last birthday): 90 — IF UNDER 1 YEAR: Months 3 Days 10 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): CLARK COUNTY MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: DAVID COALEY
13b. MOTHER'S MAIDEN NAME: MILLIE GILLETTE
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): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: EDWARD PATTERSON Address: 20 CONWAY RD

MEDICAL CERTIFICATION

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)	ACUTE CONGESTIVE HEART DISEASE	SUDDEN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	HYPERTENSIVE HEART DISEASE	2
DUE TO (c)	HYPERTENSION	2

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. ☐ Yes ☒ No ☐ Unknown

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 Aug 15-1959 to Aug 25-1959 and last saw her/him alive on Aug 22-1959
Death occurred at 11:30 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.D.
22b. ADDRESS: 117 S. Miami, St Louis, MO
22c. DATE SIGNED: Aug 25, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: Aug 28-59
23c. NAME OF CEMETERY OR CREMATORY: RIVERVIEW CEMETERY
23d. LOCATION (City, town, or county) (State): LOUISIANA MO
24. FUNERAL DIRECTOR: A.H. BOCKLAGE ADDRESS: 6536 CLAYTON RD
25. DATE RECD. BY LOCAL REG.: Aug 25-59
26. REGISTRAR'S SIGNATURE: Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed Buckeley J W

Signature of Student Embalmer

Licensed Embalmer No. 3653

P. O. Address St. Lou

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