

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED JUL 31 1961 / 00

**-61-024632**  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 76

AMENDED

DATE AMENDED

INSTEAD OF

FILE NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Dent</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Texas TWP</b>			Length of stay in lb		c. CITY OR TOWN <b>Salem Rt. 5, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Texas TWP-Dent Co.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt. 5 Salem, Mo.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Viola Patterson</b>				4. DATE OF DEATH Month Day Year <b>July 24, 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1892</b>	9. AGE (last birthday) <b>69</b>	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) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (City and state or country) <b>Dent, County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>	
13a. FATHER'S NAME <b>Andy Summers</b>			13b. MOTHER'S MARDEN NAME <b>Caroline Summers</b>		14. NAME OF HUSBAND OR WIFE <b>Frank Patterson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT <b>Frank Patterson Salem, Rt. 5, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of cervix. (8091)</b>							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)					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>2/23/46</u> to <u>7/22/61</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>4/6/61</u> Death occurred at <u>4:20 pm</u> <input checked="" type="checkbox"/> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Martin Martin</i> (Degree or title)				22b. ADDRESS <i>Salem, Mo.</i>		22c. DATE SIGNED <i>7/27/61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 26, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dry Fork</b>		23d. LOCATION (City, town, or county) (State) <b>Dent Co. Missouri</b>		
24. FUNERAL DIRECTOR <b>SPENCER FUNERAL HOME INC. SALEM, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>7/26/61</b>		26. REGISTRARS SIGNATURE <i>M. M. West, M.D. Ly Ann</i>	

**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 Carl H. Spive

Licensed Embalmer No. 2370

P. O. Address Salem, VA

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.