

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045791

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 387

STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY <u>Pettis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> Length of stay in 1b <u>39 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Campbell Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u> c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>901 So. Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>Edith</u> Last <u>PATRICK</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1961</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>1-17-1881</u>
9. AGE (last birthday) <u>80</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Malta Bend Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>W. S. A.</u>		13a. FATHER'S NAME <u>James England</u>	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <u>Edwin H. Patrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Lester Patrick</u> Address <u>Sedalia</u>
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>Senile Dementia</u> DUE TO (b) <u>Generalized 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>Several yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Intestinal right tumor</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 type="checkbox"/> NO <input checked="" 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 checked="" 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>11 Oct 61</u> to <u>14 Dec 61</u> and last saw her <u>live on 9 Dec 61</u> Death occurred at <u>0530, 14 Dec 61</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Corde Siegel M.D.</u>		22b. ADDRESS <u>146 West 18th St Sedalia Mo</u>	22c. DATE SIGNED <u>15 Dec 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) <u>Sedalia</u> (State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Mrs Laughlin Bros</u> ADDRESS <u>Sedalia</u>		25. DATE RECD. BY LOCAL REG. <u>12-15-1961</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed K. P. McCreary

Licensed Embalmer No. 3153

P. O. Address Sedalia, Mo

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.