

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000927

STATE FILE NUMBER

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 6

FILED JAN 15 1963

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant</u>		Length of stay in lb <u>2 YRS</u>	c. CITY OR TOWN <u>1 mi S. Louisburg, MO</u> Inside Limits <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harley (wmi) Patterson</u>			4. DATE OF DEATH Month Day Year <u>Jan 8 1963</u>
5. SEX <u>Male</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>Sept 20 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FORMING</u>	9. AGE (last birthday) <u>86</u> IF UNDER 1 YEAR Months Days Hours Min. <u>3 18</u>
11. BIRTHPLACE (City and state or country). <u>LOWD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Robert R. Patterson</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		14. NAME OF HUSBAND OR WIFE <u>Irene Patterson</u>	
16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>W.D. Patterson</u> Address <u>Louisburg, MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombus (recurrent) One year</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Vascular Sclerosis</u> <u>==== indefinite</u>			
DUE TO (c) <u>Senile changes</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 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. _____			
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>October 1962</u> to <u>1/8/1963</u> and last saw <u>him</u> alive on <u>1/2/1963</u> Death occurred at <u>10-A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Urbana-Mo.</u>	22c. DATE SIGNED <u>1-10-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>	23b. DATE <u>1-10-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Park Co. MO.</u>
24. FUNERAL DIRECTOR <u>Allen W. Vaughan, Urbana, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1/14/1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urbana, 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.