

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-021178

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 154

DO NOT WRITE ON THIS STUB AMENDED

VS 300  
Rev. 4/59

1 0928

2 0928

3

4 0

5 0

6

7 0

8 1

9 057.0

10

11

12 1-0

13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

<b>FILED MAY 24 1963</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Charles</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>1 Day</u>		a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Charles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS <u># 12 Oxford Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Frank</u> Last <u>Patke</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1963</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17/1959</u>	9. AGE (last birthday) <u>3</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>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Patke</u>			13b. MOTHER'S MAIDEN NAME <u>Helen Toennies</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>			16. SOCIAL SECURITY NO. <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>		17. INFORMANT Address <u>JOE PATKE St. Charles, Mo.</u>		
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) <u>Meningo coccal meningitis</u>							
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 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.)			
20c. TIME OF INJURY Hour _____ s.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	
21. I attended the deceased from <u>May 18 1963</u> to <u>May 19 1963</u> and last saw <u>alive</u> on <u>May 19</u>							
Death occurred at <u>1:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Arnold Reuland M.D.</u>				22b. ADDRESS <u>207 N. Fifth Street</u>		22c. DATE SIGNED <u>5-20-63</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Removal</u>		23b. DATE <u>5/20/1963</u>		23a. NAME OF CEMETERY OR CREMATORY <u>St. Francis Borgia</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5/20/63</u>		26. REGISTRAR'S SIGNATURE <u>Mary E. Jackson, Act. Dir.</u>		

USE BLACK INK OR TYPEWRITER RIBBON

0748  
06820

0  
0  
0  
1

0-1  
0-4

**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

*Connie L. Pakering*

Licensed Embalmer No. 5199

P. O. Address St. Charles, 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.

of, no trip. 20, 1920. 10 10 20