

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17550

State File No. \_\_\_\_\_

FILED JUN 11 1945  
278

Registration District No. \_\_\_\_\_

Primary Registration District No. 5781

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Rural - Clay Center  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community Life  
years, months or days)

3. (a) PRINT FULL NAME GRANT PATTERSON

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Emmalene Patterson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 19 1867  
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Union Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Joseph Patterson  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Clemmons  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Chester Patterson  
(b) Address Warkins Mo

17. (a) Burial (b) Date thereof 4-21-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Mo

18. (a) Signature of funeral director Chas. E. H. H. H.

(b) Address Union Mo

19. (a) Apr. 25 1945 (b) Mrs. C. R. Hankins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Union Mo - R#1  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19  
year 1945 hour 11 minute 9 M.

21. I hereby certify that I attended the deceased from June 1941 to April 1945

that I last saw him alive on April 17 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Secondary Infection Deceiving Wleers from being in bed with Due to Gouty with Cardiac renal Vascular Disease Very bad Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M. E. Humphrey (M.D. or other) P.O.  
Address Union Mo Date signed 4-23-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1388

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Miller County Health Dept.

County File Number 45-53

Date Filed 6-6-45

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Chasey*

Licensed Embalmer No.

2694

P. O. Address

Berea, 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 this body is not embalmed, fact should be so stated above.