

REC'D AUG 23 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25828
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 506
 (b) Township Boston Primary Registration District No. 5671 Registered No. _____
 (c) City New Boston (d) Street No. _____
 (e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mellie E Patrick 362

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3, 1938

5A. IS MARRIED, WIDOWED, OR DIVORCED? HUSBAND OF Martha Ideal Patrick (OR) WIFE OF _____

22. I HEREBY CERTIFY, that I attended deceased from Mar 15, 1937 to June 15, 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 28-1862

I last saw him alive on June 15, 1938 Death is said

7. AGE YEARS 76 MONTHS 2 DAYS 5 If LESS than 1 day, _____ hrs. _____ min.

To have occurred on the date stated above, at 39 a.m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Carcinoma of Maxilla (upper) 10/1936?
45 yrs
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ludlow, Mo

Other contributory causes of importance:
Chronic Fibroid
Hypertension 1930?

FATHER 13. NAME Harold Patrick
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER 15. MAIDEN NAME Donna Kinn
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Donna Kinn

17. INFORMANT (ADDRESS) Fannie Bailey

Name of operation _____ Date of _____
 What test confirmed diagnosis? unavailable Where an autopsy? no

18. BURIAL, CREMATION, OR REMOVAL PLACE Grantsville DATE July 3, 1938

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. H. Kelly
Mrs. J. M. J. Kelly

Manner of injury _____
 Nature of injury _____

20. FILED 7-3 1938 Local Registrar. 454

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Ro. P. Haley, M. D.
 (Address) Brookfield, Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

BE 3
1/10/11
1/10/11
1/10/11

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.