

N. B. - 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.

REC'D MAR 23 1939

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

7693  
 Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois 3 Registration District No. 773

(b) Township St. Francois 1 Primary Registration District No. 6018A Registered No. 18

(c) City Farmington (d) Street No. State Hospital No 4 St.   
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SARAH CAROLINE PATTERSON

(a) Residence, No. Poplar Bluff, Missouri 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

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married (Separated)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. S. Patterson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1-1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	82	9	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Milliner

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 131

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-7- 1939

I HEREBY CERTIFY, That I attended deceased from January 26 1939 to 2-7 1939

I last saw him alive on February 6, 1939 Death is said to have occurred on the date stated above, at 9:20 Am.

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

Arteriosclerosis, general + marked softening of the Brain (Pt. temporal Region)

Date of onset ?

Other contributory causes of importance:

Chronic Heart Disease with hypertrophy + hypertension (Arteriosclerotic in type) ?

Chronic interstitial nephritis ?

Senile Prostate, Subile Detention 4 yrs ago

Name of operation none Date of

What test confirmed diagnosis? Clinical Was there an autopsy? Yes

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.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) C. C. Oult M. D.  
699 (Address) Farmington, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) McClainesborough Illinois

FATHER

13. NAME Dellaware Jones

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER

15. MAIDEN NAME Harriet Galbreath

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT Records of State Hospital #4 (ADDRESS) Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL Ash Hill Cem, PLACE Poplar Bluff, Mo. DATE Feb 8-1939

19. FUNERAL DIRECTOR (NAME) Frank Und Co. (ADDRESS) Poplar Bluff, Mo.

20. FILED Feb 11 1939 93 J. Robinson Local Registrar.

**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, .....

*J. Richard Reynolds*

or by .....

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

Signed

*J. Richard Reynolds*

Licensed Embalmer No. ....

*3218*

P. O. Address

*Poplar Bluff*

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.