

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 247
Registrar's No. 247

Registration District No. 701 Primary Registration District No. _____

1. PLACE OF DEATH: 100%
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Bethesda Hospital
(d) Length of stay: In hospital or institution 4 Weeks
In this community 30 years, months or days

8. (a) PRINT FULL NAME Billie Joan Patterson
(b) If veteran, name war No (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 24, 1935
(Month) (Day) (Year)

8. AGE: Years 4 Months 4 Days 13 If less than one day hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER
12. Name Wm Patterson
13. Birthplace Bonne Terre Missouri
14. Maiden name Lillian Sayers
15. Birthplace Matthews Missouri

16. (a) Informant's own signature Wm Patterson
(b) Address 2733 Caroline

17. (a) Burial (b) Date thereof 1/10/40
(c) Place: burial or cremation St. Matthews Cem

18. (a) Signature of funeral director A. N. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) JAN 9 1940 (b) J. B. Bostick
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 2733 Caroline
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 7 year 1940 hour 3 minute 35 P.M.
21. I hereby certify that I attended the deceased from December 6 1939, to January 7 1940;

that I last saw her alive on January 7 1940, and that death occurred on the date and hour stated above.
Immediate cause of death lymphosarcoma of mediastinum
Diagnosed confirmed diagnosis

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: AA
Of operations _____
Of autopsy Massive encroachment of mediastinum by tumor

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? _____
(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 Engene P. Pitts, M.D. (M. D. or other) _____
Address 7649 Vista, St. Louis Date signed 1/7/40

Duration onset of symptoms 12/1/39
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

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.

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

L. R. Casper

Licensed Embalmer No.

3633

P. O. Address

2317 Lafayette

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.