

WHITE PRINT—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.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs 1 mo 9 da
(Specify whether years, months, days) 25 yrs

In this community _____ years, months, days

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Myrtle Patterson
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased 1 (Month) 5 (Day) 1885 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>1</u>	<u>7</u>	<u>hr.</u> <u>min.</u>

9. Birthplace Washington Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business Paint Co.

MOTHER

12. Name William Patterson
13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Hull
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Reind
(b) Address Robert Koch Hospital Record

17. (a) Burial (b) Date thereof 2/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Traber-Welders
(b) Address 2331 Broadway

19. (a) FEB 12 1940 (b) 9 R. Koch Hospital
(Date recorded local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 0 930 Putzet
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12
year 1940 hour 2 30 minute AM

21. I hereby certify that I attended the deceased from July 3, 1936, to Feb 12, 1940
that I last saw him alive on Feb 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage due to Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 23

Major findings: Of operations _____
Of autopsy Pulmonary Hemorrhage Pulmonary TB

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 Paul Murphy (M. D. or other) _____
Address Robert Koch Hospital Date signed 2-12-40

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 *Frank J. Wyland Sr.*
Licensed Embalmer No. *2675*
P. O. Address *St Louis 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, above space should be left blank.