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WED OCT 10 1940

Registration District No. 104

Primary Registration District No. 3008

State File No. _____

Registrar's No. 255

1. PLACE OF DEATH Callaway

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution State Hosp #1 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days, 6 hrs 27 days 0
(Specify whether)

In this community ✓✓
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Fulton
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME W. H. Owen Patton

3. (b) If veteran, name war na 3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30th
year 1940 hour 9 minute 15 M.

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased DK
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8/1, 1938, to 9/30, 1940;
that I last saw him alive on 9/30, 1940;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
64 DK DK DK hr. min.

Immediate cause of death Atherosclerosis

Due to _____

Due to AA

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

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

10. Usual occupation Second Hand Dealer 9

Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name DK

13. Birthplace DK
(City, town, or county) (State or foreign country)

14. Maiden name DK

15. Birthplace DK
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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?
(Specify type of place) (e) Means of injury _____

16. (a) Informant State Hosp #1
(b) Address Fulton Mo.

17. (a) Burial (b) Date thereof Oct 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willow Cemetery

18. (a) Signature of funeral director L. S. Wallack

(b) Address Fulton, Mo.

19. (a) Oct. 7, 1940 (b) R. N. Crew 0/6
(Date received local registrar) (Registrar's signature)

23. Signature H. Ford (M. D. or other) any
Address State Hosp #1 Date signed 9/30/40

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

MOTHER FATHER

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..... *Leo B. Wallace*

Licensed Embalmer No. *3373*

P. O. Address *Fulton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING: (Failure to comply with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 315-73

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Fulton
(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 _____ years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME W. H. Owen Patton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Sept day 30 year 1940 hour _____ minute _____ M.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

21. Immediate cause of death _____

Due to _____

Due to _____

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

Major findings: _____

Of operations _____

Of autopsy _____

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 G. J. Wood (M. D. or other) _____

Address Fulton Mo Date signed _____

State Hosp.

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

