

Registration District No. 6180

FILED DEPT. OF HEALTH
NOV 11 1940

Primary Registration District No. 1080

1. PLACE OF DEATH:

(a) County Washington Co
(b) City or town Spaulding
(c) Name of hospital or institution:
1. Hamilton
(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 2

3. (a) PRINT FULL NAME Christopher L. Patsen
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife May Patsen 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 11 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Crofford (City, town, or county) Mo (State or foreign country)

10. Usual occupation _____

11. Industry or business Farmer

12. Name Robert Patsen

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

14. Maiden name Louisa Armsley

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

16. (a) Informant George Ray

(b) Address Patsen Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Shirley Mo

18. (a) Signature of funeral director W. Parks
(b) Address Patsen Mo

19. (a) Nov 10 1940 (Date received local registrar) (b) J. D. Hill (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wash
(c) City or town Rural (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 1940
year _____ hour 3 minute A M.
21. I hereby certify that I attended the deceased from Nov. 2 1939, to Nov. 2 1940
that I last saw him alive on Oct 20 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
Due to Arteriosclerosis

Due to _____
Other conditions (Include pregnancy within 3 months of death) J. D. Hill

Major findings: _____
Of operations _____
Of autopsy _____

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? SO

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Jon. L. Thurman (M. D. or other) _____
Address Patsen, Mo. Date signed 11-5-40

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

5-17-39
P-I X21492

40037

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.