

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
Thomas G. Phillips
(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

3. (a) PRINT FULL NAME: *William Patton*
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: *Male* 5. Color or race: *Col* 6. (a) Single, widowed, married, divorced, *divorced*

6. (b) Name of husband or wife: *Bessie Sand* 6. (c) Age of husband or wife if alive: *45* years

7. Birth date of deceased: *Mar 17 1889*
(Month) (Day) (Year)

8. AGE: Years: *51* Months: *9* Days: *5* If less than one day: _____ hr. _____ min.

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

10. Usual occupation: *Laborer*

11. Industry or business: _____

12. Name: *William Patton*

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

14. Maiden name: *Margaret*

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

16. (a) Informant: *Bessie Sand*

(b) Address: *1307 1/2 N Jefferson*

17. (a) *Burial* (b) Date thereof: *12-27-40*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Greenwood*

18. (a) Signature of funeral director: *G. A. Green*

(b) Address: *2915 Franklin Ave*

19. (a) *DEC 27 1940* (b) *J. F. Brewer*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Mo* (b) County: _____
(c) City or town: *St. Louis* 19
(If outside city or town limits, write "RURAL")
(d) Street No.: *4175 Washington*
(If rural, give location)
(e) If foreign born, how long in U. S.: *No attending Physician* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: *Dec* day: *22*
year: *1940* hour: *9:10* minute: _____ M.

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

Immediate cause of death: _____

Lobar Pneumonia

Due to: _____

Due to: *Cholera*

Other conditions: *108*
(Include pregnancy within 3 months of death)

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: *Thomas G. Callaway* (M. D. or other)

Address: *Deputy Coroner* Date signed: *12/28/40*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

E. A. Green

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

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.