

Registration District No. **174**

Primary Registration District No. **200**

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**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **160 days**
In this community **160 days**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Alta M. Patterson**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **436-12-9559**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **Separated**
6. (b) Name of husband or wife **Paul Patterson** 6. (c) Age of husband or wife if alive **4** years
7. Birth date of deceased **4 - 17 - 1922**
(Month) (Day) (Year)

8. AGE: Years **19** Months **3** Days **24** If less than one day hr. min.

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

10. Usual occupation **waitress**

11. Industry or business

MOTHER FATHER { 12. Name **Nash Scott**
13. Birthplace **?** ?
(City, town, or county) (State or foreign country)
14. Maiden name **Thelma Kelly**
15. Birthplace **CO Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Koch Hosp. Records**
(b) Address **St. Louis County**

17. (a) **BURIAL** (b) Date thereof **8-11-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **NEW PICKERS CEM**

18. (a) Signature of funeral director **ARTHUR J. DONNELLY**
(b) Address **3840 LINDSELL BLVD**

19. (a) **AUG 10 1941** (b) **E. G. McLaughlin**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **800**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL.") **9**
(d) Street No. **3847 McRee**
(If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **8** year **1941** hour **3** minute **50 P** M.

21. I hereby certify that I attended the deceased from **2-28** 19**41** to **8-8** 19**41**
that I last saw her alive on **8-8** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**
Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy **1361**
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 **William Stuber** (M. D. or other) **D**
Address **Robert Koch Hospital** Date signed **8-9-41**

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

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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 W H Van Matre
Licensed Embalmer No. 2825
P. O. Address 4340 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, fact should be so stated above.