

S. No. 2  
4-1-44  
5-17-49  
PI X2350

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22161

State File No. ....

FILED JUL 9 1943

Registration District No. 276

Primary Registration District No. 5947-4410

Registrar's No. ....

**1. PLACE OF DEATH:**

(a) County Shelby Co  
 (b) City or town St James  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution St James Hospital  
(If not a hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 24 hours (Specify whether years, months or days)

In this community 24 hours (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Washington  
 (c) City or town Rural B10  
(If outside city or town limits, write "RURAL")  
 (d) Street No. .... (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country 1

**3. (a) PRINT FULL NAME** Patricia G Lathcart  
 3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 30  
 year 1943 hour 12 noon minute ..... M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Child  
 6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years (Month) (Day) (Year)

7. Birth date of deceased Nov 18 1933  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-24 1943 to 6-30 1943  
 that I last saw her alive on 6-30 1943  
 and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>9</u>	<u>7</u>	<u>12</u>	..... hr. .... min.

Immediate cause of death Shock  
T. Cardiac failure

Duration

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

Due to Burns over 3/4 of entire body  
 Due to Coloel Explosion

10. Usual occupation .....  
 11. Industry or business .....

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

**MOTHER FATHER**

12. Name Sagan Lathcart  
 13. Birthplace Steubenville Mo  
(City, town, or county) (State or foreign country)  
 14. Maiden name Glydes Kimberlin  
 15. Birthplace Antonia Mill Mo  
(City, town, or county) (State or foreign country)

Major findings: Of operations no  
 Of autopsy no

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Glydes Kimberlin  
 (b) Address Antonia Mill Mo  
 17. (a) Rural (b) Date thereof July 2 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation privately at home  
 18. (a) Signature of funeral director E. J. Sparks  
 (b) Address Polaski Mo  
 19. (a) 6-1-1943 (b) Chasie Dickson  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Accident + 10  
 (b) Date of occurrence 6-29-43  
 (c) Where did injury occur? Washington (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home while working on farm  
 While at work? yes (Specify type of place) (e) Means of injury Burns  
 23. Signature E. J. Sparks (M. D. or other)  
 Address St James Hospital St James Date signed 6-30-43

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

AUG 9 1944

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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.....

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, fact should be so stated above.**