

Registration District No.

318

Primary Registration District No.

1002

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 24 days
In this community 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 2126 Division
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Sarah Patterson

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female 5. Color or race W.C.C.P.
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased About 1882
(Month) (Day) (Year)

8. AGE: Years About 61 Months Days If less than one day hr. min.

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

10. Usual occupation HOUSE-KEEPER

11. Industry or business —

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Grant Johnson

(b) Address 9136 Ashlon

17. (a) RURAL (b) Date thereof SEP-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Missouri Ind. Co.

(b) Address 2631 Bayville

19. (a) SEP 11 1943 (b) J.F. Beedee
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 6,
year 1943 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 12,
1943 to September 6, 1943
that I last saw her alive on September 6, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Cardiac Hypertrophy } Autopsy Terminal
Duration Unk.

Due to —

Due to —

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

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? —

While at work? — (Specify type of place) (c) Means of injury —

23. Signature J.E. Smith (M. D. or other) —
Address Shelburne Date signed 9/7/43

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.....
Licensed Embalmer No..... 5522

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.