

7. S. No. 2
00M-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE -
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8109

State File No.

FILED APR 6 1945

318

1003

Registrar's No.

2729

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Enroute City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
8 Years (Specify whether
In this community 8 Years
years, months or days)

3. (a) PRINT FULL NAME Thenia E. Patten

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ray 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased: March 19 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 0 4 hr. min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Christopher Crane

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

14. Maiden name Martha Anthony

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

16. (a) Informant Ray Patten

(b) Address 1916 Hickory

17. (a) Motor (b) Date thereof 3/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newburg Missouri

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) MAR 27 1945 (b) J. F. Bredeck
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1916 Hickory (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23
year 45 hour 2 minutes 30 P. M.

21. I hereby certify that I attended the deceased from May 1943 to March 23, 1945
that I last saw him alive on Mar 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary Occlusion 1 day
Hypertension 3 yrs.
Arteriosclerosis 40 yrs.
Other conditions: Epilepsy 20 years
Major findings:
Of operations no
Of autopsy no

Duration
1 day
3 yrs.
40 yrs.
20 years
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 F. Swickelby (M. D. or other) MD
Address 1935 Park Ave Date signed 3-24-45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

68126

68126

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..... *R. K. Cooper*

Licensed Embalmer No. *3633*.....

P. O. Address..... *2317 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.