

No. 1-5-43
5-17-39
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35714

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 29 1945

Registrar's No. 10148

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(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 33 days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL") 11/17
(d) Street No. 4108 St. Ferdinand
(If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Patterson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1945 hour 3 minute 15 A. M.
21. I hereby certify that I attended the deceased from 9-26
1945 to 11-19 1945;
that I last saw him alive on 11-19 1945;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race negro 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife Sallie Lee Patterson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 19 1878
(Month) (Day) (Year)

Immediate cause of death Degenerative Heart Disease Duration Unk.

8. AGE: Years 67 Months 22 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business unemployed

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Ralph J. Foster
(b) Address 4108 St Ferdinand

17. (a) Burial (b) Date thereof 11 23 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Worshipers Pk
7th & Wackerly

18. (a) Signature of funeral director J. F. Bredich
(b) Address 2792 St.oddard st

19. (a) NOV 24 1945 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy No

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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____
23. Signature W. B. Bernard (M. D. or other) _____
Address 2601 N. Webster Date signed 11/21/45

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

STATE OF MISSISSIPPI

10148

10148

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.

Registration District No. 318

Primary Registration District No. 1003

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(b) City or town St. Louis
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(c) Name of hospital or institution: _____
(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

James Patterson

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased May 19 (Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ (If less than one day hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) DEC 3 1945 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1945 hour _____ minute _____ M.

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

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

35714