

FILED OCT 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34517

State File No. _____

BIRTH NO. 59361-49 REG. DIST. NO. 238 PRIMARY-REG.-DIST. NO. 4355 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <u>NEW MADRID</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>NEW MADRID</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NEW MADRID</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NEW MADRID</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>BABIE</u> b. (Middle) <u>PATTERSON</u> c. (Last) <u>PATTERSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 11-1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Oct 2-1949</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>9</u> Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during past 6 months if retired) <u>Ch. H.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>NEW MADRID, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>PROVER EDWARDS</u>	13b. MOTHER'S MAIDEN NAME <u>Lillian EARL PATTERSON</u>	14. NAME OF HUSBAND OR WIFE <u>No</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edward Johnson</u> ADDRESS <u>NEW MADRID, MO</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>11:30</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>NO MEDICAL ATTENDANT</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>By All Record</u> DUE TO (c) <u>DEATH WAS DUE TO</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>PNEUMONIA</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>L. H. ...</u>	23b. ADDRESS <u>New Madrid</u>	23c. DATE SIGNED <u>Oct 11-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 11, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sandhill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Madrid, MO</u>
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DATE REC'D BY LOCAL REG. <u>10-16-49</u>	REGISTRAR'S SIGNATURE <u>Helena Louise Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Friends</u> ADDRESS <u>216</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 25 1949

District Health Office No. 2,

District File Number 1049-1074

Date Filed _____

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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

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.