

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

6593

State File No.

1930

Registrar's No.

FILED MAR 10 1950

318

1003

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

1. PLACE OF DEATH
a. COUNTY

.....

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri b. COUNTY Pushmataha

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place)
OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tuskahoma 8350

d. FULL NAME OF HOSPITAL OR INSTITUTION Frisco Hospital

d. STREET ADDRESS (If rural, give location) 0

3. NAME OF DECEASED
(Type or Print)

a. (First) John

b. (Middle) B.

c. (Last) Patrick

4. DATE OF DEATH (Month) (Day) (Year)
Feb 26 1950

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Feb. 14 1888

9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Mins. 62 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Crosses, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME R. E. Patrick

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Martha Patrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mark Lunsford Fayetteville, Ark.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of neck
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Leukoplakia of lips 1945
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH July 1949

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Dissection of submaxillary Node July 1949

20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 1997

22. I hereby certify that I attended the deceased from 1-10-, 1950 to 2-26-, 1950, that I last saw the deceased alive on 2-26-, 1950, and that death occurred at 4:35 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Remond Miller MD

23b. ADDRESS 3610-16 S. Broadway

23c. DATE SIGNED 2-26-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 2-27-50

24c. NAME OF CEMETERY OR CREMATORY Fairview,

24d. LOCATION (City, town, or county) (State) Fayetteville, Arkansas

DATE REC'D BY LOCAL REG. Feb 27-1950

REGISTRAR'S SIGNATURE J. B. Keaster

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington

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

MAY 1950
JUN 5 1950

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.....
..... Student Embalmer No.
working under my personal supervision.

Signed
Student Embalmer

Signed *J. W. Pinkley*
Licensed Embalmer No. *3683*

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.