

FILED NOV 10 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33773

State File No. 4637

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION. <b>Trinity Lutheran</b>                                |  | d. STREET ADDRESS (If rural, give location) <b>2300 Independence Ave.</b>   |  |

|                                     |                         |                        |                            |  |
|-------------------------------------|-------------------------|------------------------|----------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>KAREN</b> | b. (Middle) <b>ANN</b> | c. (Last) <b>PATTERSON</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>10 30 51</b> |
|-------------------------------------|-------------------------|------------------------|----------------------------|--|

|                  |                            |   |                                   |  |                        |                        |                       |
|------------------|----------------------------|---|-----------------------------------|--|------------------------|------------------------|-----------------------|
| 5. SEX <b>Fe</b> | 6. COLOR OR RACE <b>Wh</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b> | 8. DATE OF BIRTH <b>10-4-1946</b> | 9. AGE (In years last birthday) <b>5</b> | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Hours | IF UNDER 15 MIN. Min. |
|------------------|----------------------------|---|-----------------------------------|--|------------------------|------------------------|-----------------------|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b> | 11. BIRTHPLACE (State or foreign country) <b>Kansas City, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b> |
|---|---|---|---|

|   |   |                                       |
|---|---|---------------------------------------|
| 13a. FATHER'S NAME <b>Lester W. Patterson</b> | 13b. MOTHER'S MAIDEN NAME <b>Anna Bell Walker</b> | 14. NAME OF HUSBAND OR WIFE <b>XX</b> |
|---|---|---------------------------------------|

|   |                                   |  |                                 |
|---|-----------------------------------|--|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> | 16. SOCIAL SECURITY NO. <b>XX</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Lester W. Patterson</b> | ADDRESS <b>2300 Indep. Ave.</b> |
|---|-----------------------------------|--|---------------------------------|

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|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><br><b>16 hours</b><br><br><b>5101</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Post tonsillectomy hemorrhage</b>  |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Removal of tonsils + adenoids</b><br>DUE TO (c) _____ |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |

|  |   |  |
|--|---|--|
| 19a. DATE OF OPERATION <b>10-29-51</b> | 19b. MAJOR FINDINGS OF OPERATION <b>9 infected tonsils + adenoids</b> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|---|--|

|  |  |   |
|--|--|---|
| 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) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **10-29-51** <sup>9:10 P.M.</sup> to **10-29-51**, 19\_\_\_\_, that I last saw the deceased alive on **10-29**, 1951, and that death occurred at **2:45** <sup>A.M.</sup> m., from the causes and on the date stated above.

|  |   |                                  |
|--|---|----------------------------------|
| 23a. SIGNATURE <b>O. S. Gilliland MD</b> | 23b. ADDRESS <b>814 Professional Bldg</b> | 23c. DATE SIGNED <b>10-31-51</b> |
|--|---|----------------------------------|

|   |                          |   |  |
|---|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>11-1-51</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b> | 24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b> |
|---|--------------------------|---|--|

|  |  |   |                        |
|--|--|---|------------------------|
| DATE REC'D BY LOCAL REG. <b>10-31-51</b> | REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Wagner</b> | ADDRESS <b>K 6 Mo.</b> |
|--|--|---|------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

11-9224

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.

Student \_\_\_\_\_  
Student Embalmer

Signed Alvin R. Harnscheidt

Licensed Embalmer No. 4159

P. O. Address D. C. Mo.

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.