

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 41

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Spgs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kearney</u>	
c. LENGTH OF STAY (In this place) <u>4 mon</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mc Adams Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARGARET ANN</u> b. (Middle) <u>PATRIC</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>March 10-52</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	
8. DATE OF BIRTH <u>June 29-1861</u>		9. AGE (In years last birthday) <u>90</u>		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 1 YEAR Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. BIRTHPLACE (State or foreign country) <u>Clay Co Mo</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Clay Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Laffoon</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Wyatt</u>		14. NAME OF HUSBAND OR WIFE <u>Edward Patric</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Walker Barr</u>		ADDRESS <u>Kearney</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>98 hrs</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		ANTECEDENT CAUSES DUE TO (b) <u>arteriosclerosis</u>					
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		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 29 Dec, 1951 to 9 Mar, 1952, that I last saw the deceased alive on 9 Mar, 1952, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>George E Anderson MD</u> (Degree or title)		23b. ADDRESS <u>Excelsior Springs Mo</u>		23c. DATE SIGNED <u>11 Mar 52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>March-12-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	
		24d. LOCATION (City, town, or county) <u>Kearney</u>		(State) <u>MO</u>	

DATE REC'D BY LOCAL REG. <u>3/10/52</u>		REGISTRAR'S SIGNATURE <u>Baseline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Fry</u>		ADDRESS <u>Kearney MO</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Leonard Fry*

Signed.....

Student Embalmer

Licensed Embalmer No. *1677*

P. O. Address *Kearney 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.