

FILED DEC 17 1954

STANDARD CERTIFICATE OF DEATH

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42697  
State File No. \_\_\_\_\_  
Registrar's No. 10974

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 10974	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 30 years		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4933 McPHERSON AVE				e. STREET ADDRESS (If rural, give location) 12 4933 McPHERSON AVE		2129 0	
3. NAME OF DECEASED (Type or Print) a. (First) LEILA		b. (Middle) WILKERSON		c. (Last) PATTERSON.		4. DATE OF DEATH (Month) (D) (v) (Year) DEC. 2, 1954	
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH Nov. 28, 1863	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Edward Wilkerson.			13b. MOTHER'S MAIDEN NAME Virginia Cline.		14. NAME OF HUSBAND OR WIFE Robert Duncan Patterson.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Walter Fischell; 4 No. Kingshighway			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of the ovary  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 2 years	
19a. DATE OF OPERATION July 9, 1953		19b. MAJOR FINDINGS OF OPERATION Generalized abdominal carcinomatosis				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? _____ 175X			
22. I hereby certify that I attended the deceased from _____, 1940, to December 1, 1954, that I last saw the deceased alive on December 1, 1954, and that death occurred at 5:25 Am., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Benjamin N. Charles M.D.				23b. ADDRESS 3720 Washington Blvd.		23c. DATE SIGNED Dec. 2, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/3/1954	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 2 1954 g. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.					

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

Student.....  
Signature of Student Embalmer

Signed *Arnold W. Schoene*.....

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.