

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 - 1955

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State File No. 2942
Registrar's No. 0304

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY <u>X</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>7</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY OR TOWN <u>Topeka</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>3632 Holly Lane</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u>	b. (Middle) <u>Pickens</u>	c. (Last) <u>Paterson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11. 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 22. 1890</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Omaha, Neb.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Pickens</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Doyle</u>	14. NAME OF HUSBAND OR WIFE <u>Kenneth H. Paterson</u>
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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 ADDRESS <u>Charles Paterson 8 Dwyer Pl. Ladue</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT - SUICIDE - HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>7</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>11/11/55 2</u>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4221</u>
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22. I hereby certify that I attended the deceased from 3-1, 1954, to 1/11, 1955, that I last saw the deceased alive on 1/11, 1955, and that death occurred at 6 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>James J. Smith, M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>730 H. Williams Ave.</u>	23c. DATE SIGNED <u>1/12/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1/13/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Omaha, Neb.</u>	24d. LOCATION (City, town, or county) (State) <u>Omaha, Nebr.</u>
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DATE REC'D BY LOCAL REG. <u>JAN 12 1955</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. A. Stock 2117 E. Grand Ave.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Pierre Wiley
730 Mediant Court
P.O. 1-5189

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..... *Frank O. Moore*

Licensed Embalmer No. *304*

P. O. Address *217 E. 2*

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.