

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 4189

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3018</u>		Registrar's No. <u>93</u>			
1. PLACE OF DEATH a. COUNTY <u>DENT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>DENT</u>					
b. CITY OR TOWN <u>SALEM</u>		c. LENGTH OF STAY (in this place) <u>8 YEARS</u>		c. CITY OR TOWN <u>SALEM 03310</u>		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 <u>305 W. 3RD ST.</u>				e. STREET ADDRESS (If rural, give location) <u>305 W. 3RD ST.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>EDWARD</u>			b. (Middle)			c. (Last) <u>PATTERSON</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 3 1957</u>			5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		
8. DATE OF BIRTH <u>MAY 12, 1894</u>			9. AGE (in years last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days		IF OVER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>REFRIGERATION</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>INK, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM PATTERSON</u>			13b. MOTHER'S MAIDEN NAME <u>MARY BOYD</u>			14. NAME OF HUSBAND OR WIFE <u>GENEVIEVE GAUFF PATTERSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>493-05-5207</u>		17. INFORMANT'S SIGNATURE OR NAME <u>GENEVIEVE PATTERSON</u>			ADDRESS <u>SALEM, MO.</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Infarction</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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) (Min.)			
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 <u>2 March, 1957</u> , to <u>3 March, 1957</u> , that I last saw the deceased alive on <u>2 March, 1957</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Ireland W. Kimball M.D.</u>				23b. ADDRESS <u>Salem, Mo</u>			23c. DATE SIGNED <u>4 Mar 1957</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MARCH 5, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SALEM MISSOURI</u>			
DATE REC'D BY LOCAL REG. <u>3/4/57</u>		REGISTRAR'S SIGNATURE <u>M M Hart</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Max L. Warfel</u>		ADDRESS <u>Salem, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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MAR 14 1957

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 Max L. Waife

Licensed Embalmer No. 4170

P. O. Address Salem, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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