

Health,
Welfare
Public
Service

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32089
STATE FILE NUMBER
4182

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4182

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3669 Jefferson</u>			Length of stay in lb <u>40 yrs</u>		d. STREET ADDRESS <u>3669 Jefferson</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Patterson</u> Last <u>Patterson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1869</u>		9. AGE (In years last birthday) <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Iven Bowman</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Taylor</u>			14. NAME OF HUSBAND OR WIFE <u>Dr. Joseph M. Patterson</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 Address <u>Barbra Hutcheson 4406 Main St. K. C. Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Artery Sclerosis</u>							<u>10 years</u>		
DUE TO (c)							<u>42 in H.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of breast with metastasis to spine and pelvis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>12-21-45</u> , to <u>9-5-57</u> and last saw her alive on <u>9-4-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>L. F. Steffen M.D.</u> (Degree or title)					22b. ADDRESS <u>1103 Grand Blvd. K.C. Mo.</u>		22c. DATE SIGNED <u>9-6-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/7/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>			23d. LOCATION (City, town, or country) <u>Kansas City Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Stine & McClure</u> ADDRESS <u>K. C. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-6-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>				

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-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, Coroner, etc.: must use only standard certificate to report. To sign otherwise will be treated as illegal.
All diseases in Part I must be causally related.

L. F. Steffen

W. J. S. 1800 and W. J. S. 1800

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 *Engene L. Fern* _____

Licensed Embalmer No. 463

P. O. Address _____

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.