

Health, Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY Y, BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 22 1957

THE DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34984

STATE FILE NUMBER

XC-2036 48 03 REG.# 15141		Registration District No. 43		Primary Registration District No. 3007		Registrar's No. 597	
1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY FULTON			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MAMMOTH SPRING		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION VETERANS ADM. HOSPITAL 12 DAYS		Length of stay in 1b 12 DAYS		d. STREET ADDRESS (If outside, give location) ROUTE THREE		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LOREN SAM PATTERSON				4. DATE OF DEATH Month Day Year OCTOBER 6, 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-11	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (City and state or country) RUSSELL, IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PATTERSON				14. MOTHER'S MAIDEN NAME LYDIA LONG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. KOREAN	17. INFORMANT UNKNOWN	Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  331X							INTERVAL BETWEEN ONSET AND DEATH 13 DAYS
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 WORK <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 Sept. 24, 1957 to October 6, 1957 Death occurred at 2:35 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Robert S. Cohen, M.D.				22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.		22c. DATE SIGNED 10/7/57	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) - (State)		
24. FUNERAL DIRECTOR Charles Dawson		ADDRESS Mammouth Springs		25. DATE RECD. BY LOCAL REG. 10/8/57		26. REGISTRAR'S SIGNATURE R. H. [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

OCT 22 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision..

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 447

P. O. Address Ref 378, al

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.