

FILED MAR 11 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004821
STATE FILE NUMBER

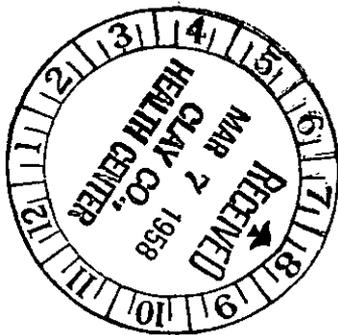
Registration District No. 41 Primary Registration District No. 3015 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>GREEN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>EXCELSIOR HOSPITAL</u>			Length of stay in lb <u>4 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>15-11 W. HIGH</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BR</u> Middle <u>HADLEY</u> Last <u>PATTERSON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22 OCT. 16 1907</u>		9. AGE (In years last birthday) <u>49</u>	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) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>RASCOE C. PATTERSON</u>			13b. MOTHER'S MAIDEN NAME <u>ADA HOLMAN</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</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>HERMAN LOHMEYER FUNERAL HOME; SPRINGFIELD, 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>Belated Broncho pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), storing the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>491X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Neuro-fibromatosis with Multiple Neurologic defects</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 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 <u>2/28/58</u> to <u>3/1/58</u> and last saw ^{her} _{him} alive on <u>3/1/58</u> Death occurred at <u>3:15 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Bugene P. Obichayo Mo.</u> (Degree or title)				22b. ADDRESS <u>Excelsior Springs, Mo</u>			22c. DATE SIGNED <u>3/2/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3-2-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE PARK</u>			23d. LOCATION (City, town, or country) (State) <u>SPRINGFIELD MO.</u>		
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> Excelsior Springs, Missouri			25. DATE RECD. BY LOCAL REG. <u>3/26/58</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Ralph Van Landingham*

Licensed Embalmer No. *42009*
P.O. Address *Acacia Springs, Me*

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.