

FEDERAL BUREAU OF INVESTIGATION
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044637

ED VS NOV 17 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3129 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DesPeres</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>St. Louis</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>Ozark Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6221 Marquette Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Ellen</u> Last <u>Patterson</u>			4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1960</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"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1878</u>
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>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Mo.</u>
13a. FATHER'S NAME <u>William Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Eads</u>	14. NAME OF HUSBAND OR WIFE <u>Lorenzo B. 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>Mrs. Augusta Smith, 6221 Marquette Ave.</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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis</u>	
	DUE TO (c) <u>generalized arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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		
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>10/14/60</u> to <u>10/25/60</u> and last saw her alive on <u>10/25/60</u> Death occurred at <u>7:55 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>1022 1/2 W. Marquette St. Kirkswood, LL Mo.</u>
22c. DATE SIGNED <u>10/28/60</u>		
23a. BURIAL CREMATION REMOVAL OR OTHER <u>HOSPITAL</u>	23b. DATE <u>10-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
25. DATE RECD. BY LOCAL REG. <u>10-28-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Melvin L. Kemper*

Licensed Embalmer No. 405

P. O. Address 4911 Wa
St. Louis m

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