

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018214

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 765

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 21 1962

VS 300  
Rev. 4/59

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28030

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>BUTLER</b>		a. STATE <b>ARKANSAS</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		c. CITY OR TOWN <b>POLLARD</b>	
Length of stay in 1b <b>3 DAYS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b>		d. STREET ADDRESS <b>ROUTE 1</b> (If outside, give location)	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <b>LOUIE</b> Middle <b>ARTHUR</b> Last <b>PATTERSON</b>			Month <b>MAY 6,</b> Day <b>1962</b> Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-95</b>
9. AGE (last birthday) <b>67</b>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>GREENWAY, ARKANSAS</b>
		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN PATTERSON</b>		13b. MOTHER'S MAIDEN NAME <b>FANNIE TODD</b>	14. NAME OF HUSBAND OR WIFE <b>DONNIE PATTERSON</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>			17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b>			<b>24 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			YEARS
DUE TO (b) <b>ARTERIOSCLEROSIS</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)			PART III. If deceased was female was there a pregnancy in last 90 days.
<b>CHRONIC BRONCHITIS WITH COR PULMONALE</b>			<input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m. 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 <b>VA MAY 3, 1962</b> to <b>MAY 6, 1962</b> <small>and last saw him alive on</small>			
Death occurred at <b>6:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S. Cohen</i> (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<b>ROBERT S. COHEN, M.D., Chief Medical Service VA HOSPITAL, POPLAR BLUFF, MO.</b>			<b>5-9-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>5-8-62</b>	<b>MITCHELL CEMETERY</b>	<b>GREENWAY CLAY ARKANSAS</b>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>RUSSELL MORTUARY PIGOTT, ARK</b>		<b>5-18-62</b>	<i>Shelton</i>

USE BLACK INK OR TYPEWRITER RIBBON

MAY 22 1962

**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 me Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gerald W. Boyce

Licensed Embalmer No. 1116

P. O. Address Regent, Ark

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.