

FILED NOV 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34498

State File No.

BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3060 Registrar's No. 303

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) -a. STATE <u>Missouri</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY OR TOWN <u>FARMINGTON</u>		c. CITY OR TOWN <u>FLAT RIVER</u>	d. Is Residence within limits of a city or incorporated town? Yes <u>A</u> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grey Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>0940</u>	

3. NAME OF DECEASED (Type or Print): a. (First) <u>RACHEL</u> b. (Middle) <u>E.</u> c. (Last) <u>PATTERSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 25 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>JAN. 12 1913</u>	9. AGE (In years last birthday) <u>42</u>	10. IF UNDER 1 YEAR (Months) <u>9</u>	11. IF UNDER 2 HRS. (Hours) <u>19</u>
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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	11. BIRTHPLACE (City and State or Foreign Country) <u>Terre Haute Ind.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>EPHRAIM POWELL</u>	13b. MOTHER'S MAIDEN NAME <u>SUSAN GILLESPIE</u>	14. NAME OF HUSBAND OR WIFE <u>PAT PATTERSON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clarence Thomas Leavelle, Mrs.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY OCCLUSION</u>		<u>30 MIN</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CARDIOVASCULAR DISEASE</u> <u>HYPERTENSIVE</u>		<u>UNKNOWN</u>
DUE TO (c) <u>OLD RHEUMATIC FEVER</u>		<u>UNKNOWN</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4/6 X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug, 1955, to October 25, 1955, that I last saw the deceased alive on Oct 17, 1955, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Marvin R. Eube</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>Farmington, Mo.</u>	23c. DATE SIGNED <u>10-26-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>OCT. 27, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>PARK VIEW CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>NEAR FARMINGTON MO</u>
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DATE REC'D BY LOCAL REG. <u>Oct. 27, 1955</u>	REGISTRAR'S SIGNATURE <u>Eather Budloff</u>	25. MINERAL DIRECTOR'S SIGNATURE <u>Raymond Caldwell</u> ADDRESS <u>Flat River, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *M*.....
Signature of Student Embalmer

Signed *R. Caldwell*.....

Licensed Embalmer No. *25*.....

P. O. Address *Filot Rd*.....

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