

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

68 0009765

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2332

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1	0
2	61
3	
4	9
5	1
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DATE AMENDED

63
22/8

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>INCARNATE WORD HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>3019 CALIFORNIA</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>ROSCOE M. PATTERSON</u>			4. DATE OF DEATH Month Day Year <u>FEBRUARY 29 1968</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/06</u>
9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PUBLISHER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>WILL PATTERSON</u>	
13b. MOTHER'S MAIDEN NAME <u>ANNIE MORRIS</u>		14. NAME OF HUSBAND OR WIFE <u>JEWELL 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>431 58 6412</u>	17. INFORMANT <u>JEWELL PATTERSON</u> Address <u>3019 CALIFORNIA</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>Arteriosclerotic heart disease with marked coronary arteriosclerotic changes,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>4:45 A</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wesley L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave</u>	22c. DATE SIGNED <u>2-29-68</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/2/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MATTHEW CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS, MO.</u>
24. FUNERAL DIRECTOR <u>THOMAS KUTIS</u> ADDRESS <u>2906 GRAVOIS</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 29 1968</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>

USE BLACK INK. OR TYPEWRITER RIBBON

3381 7 9AM 1987

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 J. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address St. Louis

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.