

DECEASED—NAME *First Middle Last* **PATMOND JAMES MACK** SEX **Male** DATE OF DEATH (Month, Day, Year) **May 7, 1969**

RACE *(White, negro, american indian, etc. (Specify))* **White** AGE—Last birthday (years) **5a. 46** UNDER 1 YEAR **5b. 46** UNDER 1 DAY **5c. 46** DATE OF BIRTH (Month, Day, Year) **6. May 31, 1916** COUNTY OF DEATH **7c. Franklin**

CITY, VILLAGE, OR LOCATION OF DEATH **7a. Columbus** INSIDE CITY LIMITS (Specify yes or no) **7b. YES** HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number) **7d. University Hospital**

STATE OF BIRTH (If not in U.S.A., name country) **8. Ohio** CITIZEN OF WHAT COUNTRY **9. U.S.** MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **10. NEVER MARRIED** SURVIVING SPOUSE (If wife, give maiden name) **11. Jean R. (Fischer) Mack**

SOCIAL SECURITY NUMBER **12a. 08-01-0841** WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **12b. NO** (If yes, give year or dates of service)

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **13a. Locomotive Crane Co.** KIND OF BUSINESS OR INDUSTRY **13b. Locomotive Crane Co.**

RESIDENCE—STATE **14a. Ohio** COUNTY **14b. Crawford** CITY, VILLAGE OR LOCATION **14c. Bucyrus** INSIDE CITY LIMITS (Specify yes or no) **14d. YES** STREET AND NUMBER **14e. 309 Joan Dr.**

FATHER—NAME *First Middle Last* **15. Osborn Mack** MOTHER—MAIDEN NAME *First Middle Last* **16. Rose Humpal**

INFORMANT—NAME **17a. Dr. John P. Mack** MAILING ADDRESS (Street or R.F.D. no., city or village, state, zip) **17b. 309 Joan Dr., Bucyrus, Ohio 44820**

PART I. DEATH WAS CAUSED BY: ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) *Myocardial* DUE TO, OR AS A CONSEQUENCE OF (b) *Bronchogenic* DUE TO, OR AS A CONSEQUENCE OF (c) *metastasis*

PART II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in part I, (a)) AUTOPSY (Yes or no) IF YES were findings considered in determining cause of death

ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (Specify) **20a.** DATE OF INJURY (Month, Day, Year) **20b.** HOUR **20c.** HOW INJURY OCCURRED (Enter nature of injury in part I or part II, item 18) **20d.**

INJURY AT WORK (Specify yes or no) **20e.** PLACE OF INJURY (At home, farm, street, factory, office bldg., etc. (Specify)) **20f.** LOCATION (Street or R.F.D. no., city, or village, state, zip) **20g.**

CERTIFICATION—PHYSICIAN I ATTENDED THE DECEASED FROM **21a. 5-15-69** TO **21b. 5-7-69** AND LAST SAW HIM/HER ALIVE ON **21c. 5-7-69** I DID/DID NOT VIEW THE BODY AFTER DEATH. **21d. DID NOT** DEATH OCCURRED (HOUR) **21e. M.** At the place, on the date, and, to the best of my knowledge, due to the cause(s) stated.

CERTIFICATION—CORONER: On the basis of the examination of the body and/or the investigation, in my opinion, death occurred on the date and due to the cause(s) stated. Hour of death **22a. 5-7-69 2:00 P.M.** The decedent was pronounced dead **22b. 5-7-69 2:00 P.M.**

CERTIFIER—NAME (Type or print) **23a. CAROL A. MILLER** SIGNATURE **23b. Carol A. Miller M.D.** DATE SIGNED **23c. 5-7-69**

MAILING ADDRESS—CERTIFIER STREET OR R.F.D. NO. CITY OR VILLAGE STATE ZIP

BURIAL, CREMATION (Specify) **24a. burial** DATE **24b. 1969** NAME OF CEMETERY OR CREMATORY **24c. Lakewood Cemetery** LOCATION (City, village, or county) (State) **24d. Bucyrus, Ohio**

NAME OF EMBALMER **25. Ralph Heistand** (LIC. NO.) **4392 A** FUNERAL DIRECTOR'S SIGNATURE (LIC. NO.) **26. N.R. ... 2441**

FUNERAL FIRM AND ADDRESS (STREET NO.) (CITY) (STATE) (ZIP) **27. Hunz-Pirnstein Funeral Home, 215 W. Main St., Bucyrus, O 44820**

DATE REC'D BY LOCAL REC. **28. 12-69** REGISTRAR'S SIGNATURE **29. [Signature]** DATE PERMIT ISSUED **30. 12-69** SIGNATURE OF PERSON ISSUING PERMIT **31. Mary L. Stanger** DIST. NO. **1701**