

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Callaway
Township McCredie or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 102 File No. 363
Primary Registration District No. 5157 Registered No. 26

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Hugh Thomas Patten

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE Single MARRIED UNBOWED OR-DIVORCED (Write the word)

DATE OF BIRTH Apr. 27 (Month) (Day) (Year) 1858

AGE 53 yrs. 8 mos. 1 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General Farming

BIRTHPLACE (City or town, State or foreign country) Callaway County Mo

PARENTS
NAME OF FATHER Robt Patten
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky Bourbon Co
MAIDEN NAME OF MOTHER Margaret M. Lammason
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bourbon Co. Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Neil
(ADDRESS) McCredie Mo.

Filed Jan 5 1912 J. W. Berry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 28, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20, 1911, to Dec 28, 1911, that I last saw him alive on Dec 27, 1911, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

82A
97 (Duration) X yrs. X mos. 8 ds.
Contributory 56 E X

(Signed) A. H. Cox M. D.
8 1911 (Address) Stephens Store Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death X yrs. 1 mos. X ds. In the State X yrs. X mos. X ds.
Where was disease contracted? Home (McCredie Twp)
If not at place of death?
Former or usual residence McCredie Twp

PLACE OF BURIAL OR REMOVAL Prairie Chapel Cemetery DATE OF BURIAL Dec 30 1911
UNDERTAKER Wolfe & Wilkins ADDRESS Bullton Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH _____
 County _____

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township _____ Registration District No. _____ File No. _____
 or _____
 Village _____ Primary Registration District No. _____ Registered No. _____
 or _____
 City _____ (NO. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH	(Month) _____, (Day) _____, 191_____ (Year)
AGE	IF LESS than 1 day _____ hrs. or _____ min.? _____ yrs. _____ mos. _____ ds.
OCCUPATION	(a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE	(City or town, State or foreign country) _____
NAME OF FATHER	_____
BIRTHPLACE OF FATHER	(City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER	_____
BIRTHPLACE OF MOTHER	(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191_____, _____, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191_____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____,
 that I last saw h_____ alive on _____, 191_____,
 and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

(Signed) _____, 191_____, (Address) _____ M. D.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.

*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Callaway
Township Mc. Credie
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 102 File No. 363
Primary Registration District No. 5151 Registered No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hugh Thomas Patton

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Apr. 27</u> 18 <u>58</u> (Month) (Day) (Year)		
AGE <u>5-3 yrs. 8 mos. 1 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>General Farming</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Callaway Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Robt. Patton</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Pentucky, Bourbon</u>	
	MAIDEN NAME OF MOTHER <u>Margaret Mc. Damahan</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Bourbon Co. Ken.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 28 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 20, 1911, to Dec. 28, 1911, that I last saw him alive on " 27, 1911, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
Complic. with Arterio-sclerosis
of arteries of brain & spine
Arterio-sclerosis (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Seizure, hemorrhage had
suggested itself about 2 mos. previous
but was curd (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. N. Cor M. D.
(Address) Stephens Star Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence Mc Credie Twp.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Neil
(ADDRESS) Mc Credie Mo.

Filled Jan 5 1923 J. H. Davis
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Oranville Chapel Cem.</u>	DATE OF BURIAL <u>Dec. 30</u> 19 <u>11</u>
UNDERTAKER <u>Godfrey Atkinson</u>	ADDRESS <u>Fulton Mo.</u>

Original file date _____ 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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