

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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH			
County	<u>Newton</u>		Registration District No.	<u>609</u>	File No.	<u>6132</u>
Township	_____		Primary Registration District No.	<u>14363</u>	Registered No.	<u>14</u>
or	_____					
Village	_____					
or	_____					
City	<u>Neosho</u>		(NO. _____ St. _____ Ward _____)			
FULL NAME <u>James Otto Patton</u>						
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH			
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Feb. 18</u> , 191 <u>2</u> (Month) (Day) (Year)			
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from			
<u>Jan 7</u> , 1900 (Month) (Day) (Year)			<u>Feb. 15</u> , 191 <u>2</u> , to <u>Feb. 18</u> , 191 <u>2</u> ,			
AGE			that I last saw him alive on <u>Feb. 18</u> , 191 <u>2</u> ,			
<u>12</u> yrs. <u>0</u> mos. <u>7</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?			and that death occurred, on the date stated above, at <u>5:20</u> p. m.			
OCCUPATION			The CAUSE OF DEATH* was as follows:			
(a) Trade, profession, or particular kind of work _____			<u>Cerebro. spinal Meningitis</u>			
(b) General nature of industry, business, or establishment in which employed (or employer) _____			<u>79th</u>			
BIRTHPLACE			(Duration) _____ yrs. _____ mos. <u>04</u> ds.			
(City or town, State or foreign country) <u>Newton Co Mo</u>			Contributory _____			
PARENTS	NAME OF FATHER	<u>C L Patton</u>	(SECONDARY) _____			
	BIRTHPLACE OF FATHER	<u>Barry Co</u>	(Duration) _____ yrs. _____ mos. _____ ds.			
	MAIDEN NAME OF MOTHER	<u>Allie E. Bridges</u>	(Signed) <u>E. L. Wiggins</u> M. D.			
	BIRTHPLACE OF MOTHER	<u>Newton Co Mo</u>	<u>Feb 18</u> , 191 <u>2</u> (Address) <u>Neosho Mo</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
(Informant) <u>C L Patton</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
(ADDRESS) <u>Neosho Mo</u>			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Filed <u>Feb 27</u> , 191 <u>2</u> , <u>W R Watson</u>			Where was disease contracted if not at place of death? _____			
Deputy - REGISTRAR			Former or usual residence _____			
			PLACE OF BURIAL OR REMOVAL			
			<u>5007 Cemetery</u>			
			DATE OF BURIAL			
			<u>Feb 19</u> , 191 <u>2</u>			
			UNDERTAKER			
			<u>Higham Co</u>			
			ADDRESS			
			<u>Neosho Mo</u>			

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH _____

(Month) _____ (Day) _____ 191_____ (Year)

AGE

IF LESS than
1 day, _____ hrs.
or _____ min.?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) _____ (Day) _____ 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:

Contributory
(SECONDARY)

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

(Signed) _____

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

(Address) _____

M. D. _____

*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 _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A P

RECORD

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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 Newton
Township _____
or
Village _____
or
City Neosho (No. _____ St.: _____ Ward _____)

Registration District No. 609 File No. 6132
Primary Registration District No. 4363 Registered No. 14

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

FULL NAME

James Otto Patton

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE S
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Jan 7, 1900
(Month) (Day) (Year)

AGE 12 yrs. 0 mos. 7 ds.
If LESS than 1 day, ____ hrs. or ____ min.

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) Newton Co Mo

NAME OF FATHER

O. L. Patton

BIRTHPLACE OF FATHER

Derry Co

MAIDEN NAME OF MOTHER

Aggie E. Bridge

BIRTHPLACE OF MOTHER

Newton Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. L. Patton

(ADDRESS) Neosho Mo

Filed April 9, 1912 W. L. Harrison Deputy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 18, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 15, 1912, to Feb 18, 1912,
that I last saw him alive on Feb 18, 1912,
and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis
Died in the Congestive
Stage (Sporadic case)
(Duration) ____ yrs. ____ mos. 1 ds.

Contributory

(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D. L. Williams M. D.
April 9, 1912 (Address) Neosho 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 _____

PLACE OF BURIAL OR REMOVAL

Laurel Cem

DATE OF BURIAL

2/18, 1912

UNDERTAKER

F. J. Bigham

ADDRESS

Neosho Mo

Original file, date 27, 1912

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*, *Compositor*, *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*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, 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.)