

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

PLACE OF DEATH

County Bute

Township _____

or

Village _____

or

City Butte (NO. _____)

Registration District No. 50

File No. 25446

Primary Registration District No. 8004

Registered No. H7

St. 1st Ward

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

FULL NAME Ora Lincolna Patts

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE black SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)

DATE OF BIRTH Nov 16, 1894
(Month) (Day) (Year)

AGE 18 yrs. 9 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or Particular kind of work Cab Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 4-10

BIRTHPLACE (City or town, State or foreign country) Henry Co. Mo.

NAME OF FATHER J. M. Patts

BIRTHPLACE OF FATHER (City or town, State or foreign country) Henry Co. Mo.

MAIDEN NAME OF MOTHER Elizabeth Smith

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Johnson Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Drake

(ADDRESS) Butte Mo.

Filed aug 27, 1913 J. C. Boulware REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8 26, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8/23, 1913, to 8/26, 1913, that I last saw him alive on 8/26, 1913, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
abscess of Brain

98A
(Duration) 1 yr. 12 mos. 6 ds.

Contributory (SECONDARY) Septicemia
(Duration) 1 yr. 15 mos. 15 ds.

(Signed) J. McCrabtree M. D.
8/27, 1913 (Address) Butte 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 Cat Hill DATE OF BURIAL Aug 27, 1913

UNDERTAKER Ad. Culver Sew Co. ADDRESS Butte Mo.

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.

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.)

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 Bates County _____
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Township _____ Registration District No. 50 File No. _____
 or Village _____ Primary Registration District No. 3004 Registered No. 47
 or City Butler (NO. _____ St. _____ Ward _____)
 FULL NAME Asa Lincoln Potts (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
SEX <u>M.</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>	DATE OF DEATH <u>Aug 26, 1913</u> <small>(Month) (Day) (Year)</small>		
DATE OF BIRTH <u>Satisfactory Information Supplied</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.		
AGE <u>Satisfactory Information Supplied</u> <small>_____ yrs. _____ mos. _____ ds. If LESS than _____ day, _____ hrs. _____ min.</small>			The CAUSE OF DEATH* was as follows: <u>Abscess of Brain</u> <u>Caused by a fever on Head</u> <u>When in a fight</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Satisfactory Information Supplied</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Typhoid</u> <small>(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.</small>		
BIRTHPLACE (City or town, State or foreign country)			(Signed) <u>J. E. Bourke</u> M. D. <u>8/27, 1913</u> (Address) <u>Butler Mo.</u>		
PARENTS	NAME OF FATHER		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER <small>(City or town, State or foreign country)</small>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	MAIDEN NAME OF MOTHER		Where was disease contracted If not at place of death? _____ Former or usual residence _____		
	BIRTHPLACE OF MOTHER <small>(City or town, State or foreign country)</small>		PLACE OF BURIAL OR REMOVAL <u>Satisfactory</u> DATE OF BURIAL _____, 191____ UNDERTAKER _____ ADDRESS <u>Supplied</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Satisfactory Information Supplied</u> (ADDRESS) _____ Filed <u>Oct 1, 1913</u> <u>J. E. Bourke</u> REGISTRAR					

SUPPLEMENTARY INFORMATION SUPPLIED

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