

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

Pettis

Township

or

Village

or

City

Sedalia

(NO.

Registration District No.

668

File No.

34475

Primary Registration District No.

9032

Registered No.

288

St.; *1st* Ward)

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

FULL NAME

David Cummings Patton

PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

white

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

DATE OF BIRTH

Feb. 25

(Month)

(Day)

(Year)

AGE

66

yrs.

9

mos.

4

ds.

If LESS than
1 day, hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Undertaker

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

Embalmer

BIRTHPLACE

(City or town, State or foreign country)

Columbus Ohio

NAME OF FATHER

George A. Patton

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ohio

MAIDEN NAME OF MOTHER

Francis

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno McLaughlin

(ADDRESS)

Sedalia mo

Filed

Nov 30, 1915

H. B. Long

REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Nov 29, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Nov 18, 1915, to Nov. 29, 1915,

that I last saw him alive on *Nov 29, 1915,*

and that death occurred, on the date stated above, at *10:30 P.*

The CAUSE OF DEATH* was as follows:

*apoplexy,
8241. Thrombophlebitis (left side)*

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Chas. W. McLaughlin

M. D.

Nov 30, 1915 (Address) *Sedalia 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

Crown Hill Cemetery

DATE OF BURIAL

Dec. 1st, 1915

UNDERTAKER

McLaughlin Bros

ADDRESS

Sedalia

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

PLACE OF DEATH

County _____
Township _____
Village _____
City _____
(NO. _____)
Registration District No. _____
Primary Registration District No. _____
File No. _____
Registered 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 (If fill the word)

DATE OF BIRTH _____ (Month) _____, 191____ (Year)

AGE _____ yrs. _____ mos. _____ 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)

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 _____

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:

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ (Address) _____, 191____ 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. 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