

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

1 PLACE OF DEATH

County Wenona  
Township.....  
or  
Village.....  
or  
City Nevada (NO..... St..... Ward.....)

Registration District No. 875 File No. 283985  
Primary Registration District No. 3039 Registered No. ....

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

2 FULL NAME Robert Edwin Patterson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE widowed  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Sept 15 1862  
(Month) (Day) (Year)

7 AGE 55 yrs 4 mos 16 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE Leon Iowa  
(City or town, State or foreign country)

PARENTS  
10 NAME OF FATHER Phillip W. Patterson  
11 BIRTHPLACE OF FATHER Iowa  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER Mary A. Beatty  
13 BIRTHPLACE OF MOTHER Iowa  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) F. B. Patterson  
(Address) Mustang Okla

15 Filed 2/1 1918 G. W. Petty Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 21 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1918 to 1918  
that I last saw him alive on 1918  
and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH\* was as follows:  
As a result of Gun Shot wound in temple Penetrating the brain of cerebral Artery  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Q. M. Trauer coroner  
(Duration) yrs. mos. ds. Feb 1, 1918  
(Address) Nevada Mo

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL Leon Iowa DATE OF BURIAL 2/3/18 1918

20 UNDERTAKER R. W. Harding ADDRESS Nevada

# 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.)

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Winn  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Winn (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 875 File No. \_\_\_\_\_  
Primary Registration District No. 3039 Registered No. 28

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

FULL NAME Robin Edwin Patterson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH _____ (Month) _____ (Day) _____ (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) _____		
PARENTS	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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 31, 1918  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1918 to \_\_\_\_\_, 1918, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1918, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
As a result of Gun shot wound in Throat Penetrating the brain of unknown origin Suicide Paroxysm, indirect

Contributory (SECONDARY) \_\_\_\_\_ (Duration) 15 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) D. M. Brown (Address) Winn, Nevada  
Apr 3, 1918

\* 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
Filed \_\_\_\_\_ 1918 \_\_\_\_\_ REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1918  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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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.)