LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

15155

153

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

LACE OF DEATH

County Bates. Registration District No. 50 File No. ~~242~~

Township Primary Registration District No. 3004 Registered No. ~~50~~

City Butler--Mo. (No. St. Ward)

ULL NAME Matilda Rebekah Patrick.

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	White	Married.

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF George Patrick.

TE OF BIRTH (MONTH, DAY AND YEAR) March 1st, 1867

E	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	56	2	1	

CUPATION OF DECEASED

a) Trade, profession, or articular kind of work Wife

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

c) Name of employer

RTHPLACE (CITY OR TOWN) LeHigh--Penn.
(STATE OR COUNTRY)

NAME OF FATHER William.McClemments

BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland.

MAIDEN NAME OF MOTHER Mary Hindman.

BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Scotland.

NFORMANT X Geo Patrick
Address) + 2411 Bird St. Joplin

ILED May 9th 1923 T. F. Lockmoor MO
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2nd.1923

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw her alive on May 2nd, 1923, 19..., and that death occurred, on the date stated above, at 4=40=P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sudden Death.

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R E Crabtree, M. D

May 3, 1923 (Address) Butler, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Fairview Cem at Joplin Mo	May 7th 1923

20. UNDERTAKER	ADDRESS
Culver's	Butler Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

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V. S. No. 2.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ..., St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17. I HEREBY CERTIFY, That I attended deceased from .....
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.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUS
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