

MAR 25 1927

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

Do not use this space.

4853

1. PLACE OF DEATH

County St. Francois  
Township Manassah  
City Bessemer (No. ....)

Registration District No. 779  
Primary Registration District No. 6024a

File No. ....  
Registered No. ....  
St. .... Ward)

2. FULL NAME

Nancy Ann Patt

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 9 mos. 10 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Christian Patt

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
42 9 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife  
(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)

Donno Twp  
Missouri

10. NAME OF FATHER

John Gabriel Thomason

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

Tennessee

12. MAIDEN NAME OF MOTHER

Genetic Harmonia Stern

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

Kentucky

14. INFORMANT (Address)

Mrs. Edith Hedgecott  
7 1st River, Mo.

15. FILED

3-7-1927 R. P. Lester

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 26 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to Feb 26, 1927, that I last saw him alive on July 26, 1927, and the death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Eurocarditis  
10 yrs. 10 mos. 10 ds.  
CONTRIBUTORY Broncho Pneumonia + (SECONDARY)  
Influenza (duration) yrs. mos. 16 ds.

18. WHERE WAS DISEASE CONTRACTED 11th  
IF NOT AT PLACE OF DEATH? 107th  
DID AN OPERATION PRECEDE DEATH? 9/18 DATE OF.....

WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) E. C. Rohbock M.D., M. D.

(Address) Star River 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 St. Francois Mo. DATE OF BURIAL Feb. 28 - 1927

20. UNDERTAKER C. J. Boyer ADDRESS DuBois 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.

MISSOURI STATE BOARD OF HEALTH



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County St. Francois Registration District No. 779 File No. ....  
 Township Desloge Primary Registration District No. 6024A Registered No. ....  
 City Desloge (No. ....) St. .... (Word) ....

2. FULL NAME Nurray Ann Ott  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31 - 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>42</u>	<u>9</u>	<u>26</u>	

**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)

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 3-7-27 R.B. Reetz

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 26 19 27

17. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY)

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)....., M. D.  
 , 19 (Address)

\*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

19

20. UNDERTAKER

ADDRESS

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

SUPPLEMENTARY

6-5853