

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

Do not use this space.

25308

84

File No. _____
Registered No. _____
St. _____ Ward _____

Registration District No. 604
Primary Registration District No. 5797

1. PLACE OF DEATH
County Missouri
Township Lafayette
City Marion (No. _____)

2. FULL NAME Cora Lee Patton
(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 Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

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

7. AGE Years Months Days If LESS than 1 day, hrs. or min. 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(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) Marion Mo

10. NAME OF FATHER Epperson Patton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Janita Patton

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

14. INFORMANT Lee Archiball (Address) Marion

15. FILED 7/13, 1929 W B Boman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-12-1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, alive on _____, 19____, and that death occurred, on the date stated above, at _____, 10 ____ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 Died with air Machine attack
Probably injured on Bush

CONTRIBUTORY (SECONDARY) 1610

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____

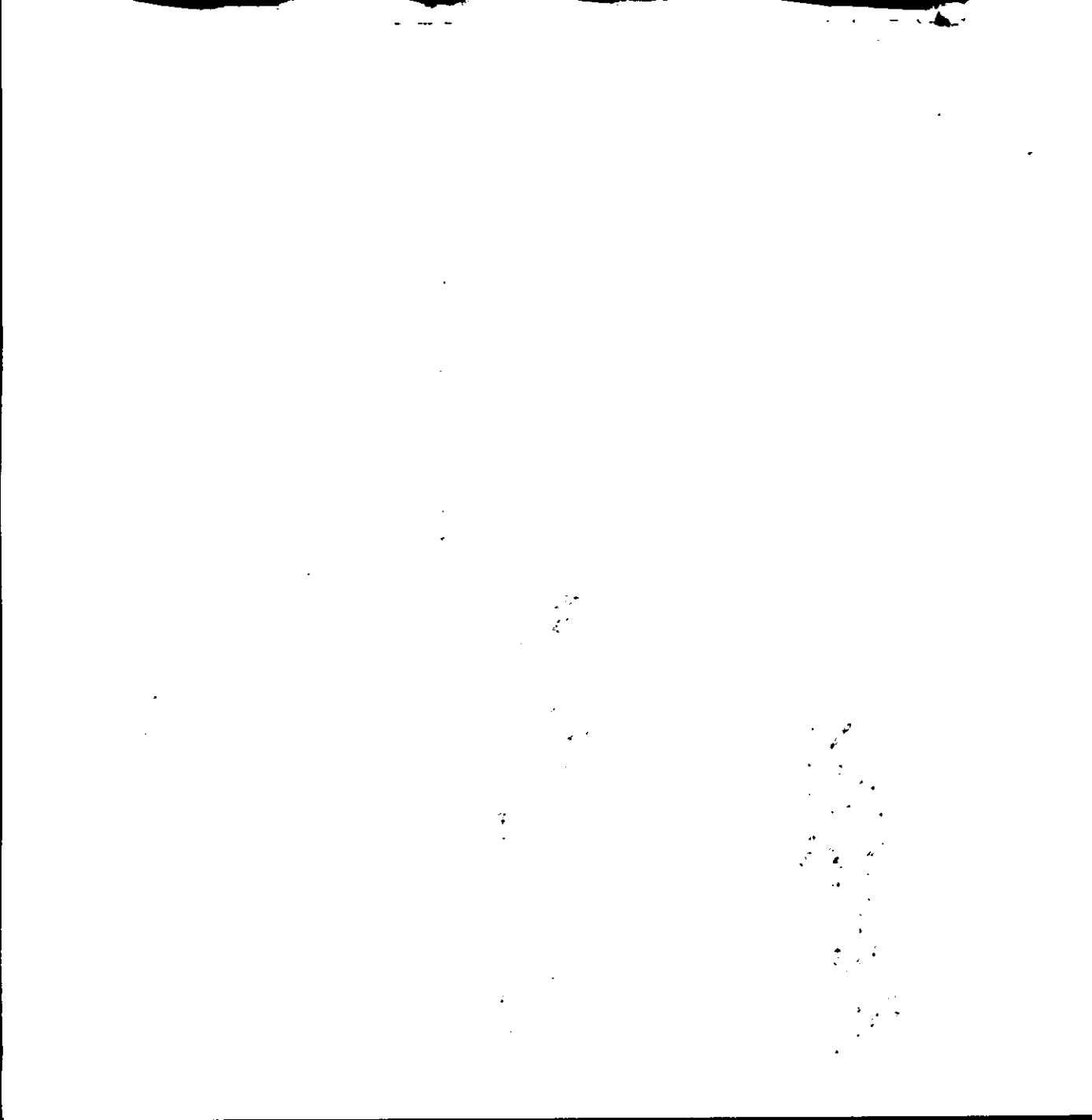
WAS THERE AN AUTOPSY, _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) W B Boman (M.D.)
, 19____ (Address) Centerville

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sanjour Powers Bur DATE OF BURIAL 7-13-1929

20. UNDERTAKER L. M. Hall ADDRESS Centerville



**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 New Madrid Registration District No. 604 File No. 84
Township Lafont Primary Registration District No. 5-798 Registered No. _____
City _____ No. _____ St. _____ Ward _____

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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/6/29

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 6

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 9/7/29 M. Bannan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/12/29

17. I HEREBY CERTIFY That I attended/deceased from _____
19____ to _____, 19____
that I last saw h. _____ 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

5-25308