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

Do not use this space.

File No. 36883
Registered No. 826

1. PLACE OF DEATH
County Greene
Township
City Springfield (No. 845 S. Ave. St. Ward)
Registration District No. 318
Primary Registration District No. 2001

2. FULL NAME Lee A. Patterson
(a) Residence. No. 845 S. Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 16 1882

7. AGE: Years 46 | Months 10 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant
(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): Mo

PARENTS
10. NAME OF FATHER: James A. Patterson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Eliza Clapp
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Mrs. L. A. Patterson
(Address) 845 S. Ave.

15. FILED 11-14, 1929 Lou Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11-13-1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw him alive on Dec. 11-13-1929, and that death occurred, on the date stated above, at 5 Cty m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Poisoning with Carbolic Acid
Suicidal
163.
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 166
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Wed DATE OF
WAS THERE AN AUTOPSY? Wed
WHAT TEST CONFIRMED DIAGNOSIS?

11/13, 1929 (Signed) Murray C. Stone, Coroner, M. D.
(Address) Springfield 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hazelwood
DATE OF BURIAL: 11-14-1929

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 3 1929

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