

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

Do not use this space.

32342

**1. PLACE OF DEATH**

County St. Louis  
Township Bonhomme  
City (No. , )

Registration District No. 785  
Primary Registration District No. 6081

File No. \_\_\_\_\_  
Registered No. 197 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** William D. Patterson

(a) Residence, No. 5560 Pershing 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male White</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Goldie Patterson</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>July 18, 1903</b>		
7. AGE YEARS <b>28</b>	MONTHS <b>1</b>	DAYS <b>26</b>
If LESS than 1 day, _____ hrs. or _____ min.		

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Welder</b>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <b>Airplane Welding</b>
	10. Date deceased last worked at this occupation (month and year) <b>Sept. 1931</b>
	11. Total time (years) spent in this occupation <b>5 years</b>

12. BIRTHPLACE (CITY OR TOWN) Richmond  
(STATE OR COUNTRY) Ark.

FATHER 13. NAME Thomas Patterson

FATHER 14. BIRTHPLACE (CITY OR TOWN) Ark.  
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Katie Smith

MOTHER 16. BIRTHPLACE (CITY OR TOWN) Ark.  
(STATE OR COUNTRY)

17. INFORMANT Goldie Patterson  
(ADDRESS) Hope Arkansas.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Hope Ark. DATE 9.17.1931 19

19. UNDERTAKER Hope Und. Co  
(ADDRESS) Hope Arkansas

20. FILED 9/14 1931 C. E. Barnett M.D.  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13, 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at 4:30 p.m.

The principal cause of death and related causes of importance were as follows:

~~Fractured skull~~  
~~Accidental fall with~~  
~~glider (aeroplane)~~  
Date of onset \_\_\_\_\_

Other contributory causes of importance  
Fractured Skull  
Accidental fall with glider (aeroplane)

Name of physician John M. ... Date of \_\_\_\_\_

What test confirmed diagnosis? Physical signs Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also as following:  
Accident, suicide, or homicide? Yes Date of injury 9.13.1931

Where did injury occur? Hope, Jones County

Specify whether injury occurred in industry, in home, or in public place.  
Public Place

Manner of injury Glider accident

Nature of injury Fractured Skull

24. Was disease of injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) John M. ... M. D.

(Address) Hope, Jones County

Page 9 of 100

