

K. 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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Dr. Calloway

OCT 4 2 1939

32422  
Do not use this space.

## 1. PLACE OF DEATH

(a) County GREENE Registration District No. 316  
 (b) Township SPRINGFIELD Primary Registration District No. 2001  
 (c) City SPRINGFIELD (d) Street No. Barge Hosp. St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Orin Patterson

(a) Residence, No. 1125 Benton St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Emily R. Patterson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 7, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
 66 7 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lawyer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Webster County 0  
 (STATE OR COUNTRY) Missouri

13. NAME John A. Patterson 0

14. BIRTHPLACE (CITY OR TOWN) Webster County 1  
 (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Lue M. Bridwell

16. BIRTHPLACE (CITY OR TOWN) Kentucky  
 (STATE OR COUNTRY)

17. INFORMANT Mrs. Emily Patterson  
 (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Maple Park DATE Sept. 26, 1939

19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer  
 (ADDRESS) Springfield, Mo.

20. FUNERAL Sept 26, 1939 Chas. A. George Mo.  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1939, to Sept 24, 1939  
 I last saw him alive on Sept 22, 1939 Death is said to have occurred on the date stated above, at 2:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Appendicitis,  
Perforated, ruptured  
General Peritonitis  
 Date of onset 9/18/39  
 171

Other contributory causes of importance:

General Peritonitis

Name of operation Appendectomy Date of 9/19/39  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) Ray D. Calloway, M. D.

(Address) Springfield, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Walter E. Samuels*

Licensed Embalmer No. ....

*3808*

P. O. Address.....

*Springfield, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

*X*