

APR 22 1927

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

Do not use this space.

4329

1. PLACE OF DEATH

County Cole

Registration District No. 213-

Township Jefferson

Primary Registration District No. 3014-

City Jefferson (No.         )

File No.         

Registered No. 60-

St.          Ward         

2. FULL NAME Bertha Clark Green

(a) Residence. No. 710 Michigan St. Ward.           
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos.          ds. How long in U.S., if of foreign birth? yrs. mos.          ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed  
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1927  
17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1927 to Feb. 27 1927  
that I last saw him alive on Feb. 26 1927, and that death occurred, on the date stated above, at 8:00 a.m.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of Wm Green

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Septicemia

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7 1899

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
37 | 9 | 30 |          day,          hrs. or          min.

CONTRIBUTORY Pelvic Cellulitis  
(SECONDARY) (duration) yrs. 2 mos. 20 ds.  
(duration) yrs.          mos. 7 ds.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) at home  
(c) Name of employer Mills Co

9. BIRTHPLACE (CITY OR TOWN) Mo  
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH same  
DID AN OPERATION PRECEDE DEATH no DATE OF           
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) Chas Mansley, M.D.  
Feb 28 1927 (Address) Jefferson City, Mo

10. NAME OF FATHER Thos Clark

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

12. MAIDEN NAME OF MOTHER Thos Clark

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

14. Mrs Thos Green  
(Address) Jefferson City

15. FILED 2/28 19 27 D. V. Bedford  
REGISTRAR

\*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 Jefferson City DATE OF BURIAL Feb 28 1927

20. UNDERTAKER Lawson Farmer ADDRESS 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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cole Registration District No. 213 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3014 Registered No. 60  
 City Jefferson City 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 \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**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 Edna M. ...  
 (Address) \_\_\_\_\_

15. FILED 2/28-27-P. V. Bedford  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 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 \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Sepsis  
Pelvic Cellulitis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Pelvic Cellulitis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

SUPPLEMENTARY

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