

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

Do not use this space.

11226

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City..... Missouri Baptist San St. _____ Ward _____

File No. _____
 Registered No. 13059

2. FULL NAME

Nellie Herzog
 (a) Residence. No. Fruitland mo. St. 12 Ward. Fruitland mo.
 (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 White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13, 1906
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
22 | 2 | 6 | _____
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business, or establishment in which employed (or employee) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
10. NAME OF FATHER Ben Herzog
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Jane McLean
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT S.P. Sides
 (Address) Fruitland mo.

15. FILED 19 Nov. C. Stankoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/19 - 19 8
17. I HEREBY CERTIFY, That I attended deceased from 2/8 -, 198, to 3/19 -, 198 that I last saw h. 24 alive on 3/18 -, 198, and that death occurred, on the date stated above, at 8:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial center
66B
93A WW (duration) _____ yrs. _____ mos. 5 da.
CONTRIBUTORY (SECONDARY) Esophthalmic Gastric (duration) _____ yrs. 8 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Immunop
 (Signed) R. Reeder, M. D.
3/19, 198 (Address) 303 Hawthorn

*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 Fruitland mo. DATE OF BURIAL March 19 28
20. UNDERTAKER Philander Craig Washington ADDRESS 468

WRITE FULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

