

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

Do not use this space.

9199

**1. PLACE OF DEATH**

County Greene Registration District No. 318 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 250  
 City Springfield mo (No. \_\_\_\_\_) Springfield Baptist St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Nellie Vert  
 (a) Residence, No. Greenfield mo. St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode)

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 <u>F</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Frank Vert</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>unknown</u>		
7. AGE	YEARS	MONTHS
	<u>59</u>	<u>-</u>
		DAYS
		<u>-</u>
		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housewife</u>	
	9. Industry or business in which work was done, as silk mill, 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) (STATE OR COUNTRY) <u>Neasbo mo</u>		
FATHER	13. NAME <u>Edwin Ebert</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Jane Herish</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
17. INFORMANT (ADDRESS) <u>Helen Wright Springfield, mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Neasbo mo</u> DATE <u>March 19 1933</u>		
19. UNDERTAKER (ADDRESS) <u>R. H. Hohmeyer Springfield mo.</u>		
20. FILED <u>3-19-33</u> <u>Ralph W. Bangert</u> Registrar		

**MEDICAL CERTIFICATE OF DEATH**

**4**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 18 1933

22. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1933, to March 15, 1933.  
 I last saw him alive on Feb. 14, 1933. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
General Peritonitis  
ruptured Gall Bladder  
1933

Other contributory causes of importance:

Name of operation Laparotomy Date of 3/15  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. H. C. Box + J. H. Kullback M. D.  
 (Address) 2234 South

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.

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39  
3  
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Richard Franklin Brown  
Worcester, Mass.

**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 Greene Registration District No. 318  
 Township \_\_\_\_\_ Primary Registration District No. 2007  
 City Springfield (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 256

**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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, 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) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 5-27-33 Rutherford Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAN, 19 \_\_\_\_\_

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

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

to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Suppurative Peritonitis  
ruptured gall bladder  
caused by impaction of  
gall-bladder from gall stones  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY

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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.

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