

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

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39767

JAN 26 1934
31

1. PLACE OF DEATH

County *Greene*

Township *Springfield*

City *Springfield*

Registration District No. *318*

Primary Registration District No. *7001*

File No.

Registered No. *895*

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *659 Marion*

(Usual place of abode)

St. _____

Ward _____

(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

Female

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

Vernon L. Hertwick

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

May 10 - 1914

7. AGE

YEARS

19

MONTHS

7

DAYS

9

If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

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

at Home

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

In Home

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)

Mo.

13. NAME

Charles C. Johnson

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

Mo.

15. MAIDEN NAME

Maud Showalter

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

Kansas

17. INFORMANT (ADDRESS)

*Vernon L. Hertwick
Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19.

19. UNDERTAKER (ADDRESS)

*J. Klingner & Co.
Springfield, Mo.*

20. FILED

19

*W. Langston
Registrar.*

1 MEDICAL CERTIFICATE OF DEATH

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

Dec 19 1933

22. I HEREBY CERTIFY, (That) I attended deceased from

Nov 1 1933, to Dec 19 1933

I last saw him alive on *Dec 15 1933* Death is said to have occurred on the date stated above, at *3 P.* m.

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

Tuberculosis of Lungs
L.M.A.
23

Date of onset
Jan 19 1933

Other contributory causes of importance:

Name of operation *none* Date of _____

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? *No.*

If so, specify *J. S. Britton* M. D.
(Signed) *J. S. Britton* M. D.
(Address) *Springfield Mo.*

[The body of the document contains several columns of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a multi-column report or document.]

**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. 918

File No. _____

Township _____

Primary Registration District No. 2001

Registered No. 895

City Springfield

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (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.
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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)

13. NAME

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

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 12-20 19 33

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19, 19 33

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:

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

Raw
Registrar

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 COMPLETED AS PRESCRIBED BY LAW.

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