WRITE PLAINLY, 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.

AUG 8 1934

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

Do not use this space.

24119

1. PLACE OF DEATH Greene
County ..... Registration District No. 318
Township ..... Primary Registration District No. 1 Y001
City Springfield (No. Burge Hospital St. ..... Ward)
File No. 348
Registered No. .....

2. FULL NAME Nellie M. Butcher
(a) Residence, No. Springfield R St. #5 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 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 Tom Butcher

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 16-1895

7. AGE YEARS 39 MONTHS 5 DAYS 2 If LESS than 1 day, ... hrs. or ..... min.

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

FATHER
13. NAME Robert Owsley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Mary Elizabeth Hall
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) Tom Butcher Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE McClain Cemetery DATE July 19 1934

19. UNDERTAKER (ADDRESS) J. W. Klingner & Co. Springfield Mo.

20. FILED 7-18 1934 [signature] Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 13, 1934 to July 18, 1934
I last saw her alive on July 18, 1934. 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
122B Acute intestinal obstruction	7-11-34
129	
122 B	

Other contributory causes of importance: massive adhesions from prior abdominal operation 2 yrs ago.

Name of operation: Intestinal resection Date of 7-18-34
What test confirmed diagnosis? Operative 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 .....
(Signed) Arthur D. Knabb, M. D.
(Address) 450 1/2 E. Court

WRITE PLAINLY, 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.

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

24 119

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 348
City Springfield (No. Burge Hospital St. Ward)

2. FULL NAME Nellie M Butcher

(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) M

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) Ralph W Langston

20. FILED 19 John W Wells Jr. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18, 1934

22. I HEREBY CERTIFY, That I attended deceased from ....19...., 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
acute Intestinal obstruction - Massive adhesions from prior abdominal operation	

Other contributory causes of importance:
Previous operation - Caecarian Section
no malignancy

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) Arthur D Knabb, M. D.
(Address) 450 1/2 E Coml.

SUPPLEMENTARY

24119