

SEP 1 1939

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

Do not use this space.

1. PLACE OF DEATH

County Coss

Township Imber

City Garden City

Registration District No. 154

Primary Registration District No. 4088

File No. 28831

Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

230 Nennetta Uea West

(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

Female

4. COLOR OR RACE

White

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

Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF  
(OR) WIFE OF

George Nelson

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

Feb 25, 1876

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

63

5

27

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

Lousabeber

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)

Garden City, Missouri

13. NAME

R.A. West

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

Clay Co. Missouri

15. MAIDEN NAME

Nannia A. Byler

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

Boonville, Missouri

17. INFORMANT (ADDRESS)

Wm West, Garden City, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE GC Cemetery DATE Aug 23, 1939

19. UNDERTAKER (ADDRESS)

Wm West, Garden City, Mo.

20. FILE

Aug 25, 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug - 18, 1939, to Aug - 22, 1939

I last seen alive on Aug - 21, 1939 Death is said to have occurred on the date stated above, at 2:40 p.m.

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

Ruptured Gallbladder Date of onset \_\_\_\_\_

Other contributory causes of importance:

Name of operation none 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 \_\_\_\_\_

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 7 B Gully, M. D.

(Signed) Wm West (Address) Garden City, 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.

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FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

28831  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Cass Registration District No. 15-4  
 (b) Township Garden City Primary Registration District No. 4288 Registered No. \_\_\_\_\_  
 (c) City Garden City (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henrietta Vera West  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
	<u>63</u>	<u>5</u>	<u>27</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 22 1939

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:  
Purified Gall Bladder  
wholly due to listeriosis  
the mother who was an invalid  
 Other contributory causes of importance:  
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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) F. B. Ellis, M. D.  
 (Address) Garden City Mo

SUPPLEMENT

Local Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND 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.

S-28831