

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

43379
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 875
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 909
 (c) City SPRINGFIELD (d) Street No. Community Hospital 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

Hettie Nellis
 (a) Residence, No. 904 E. Central St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 18 - 1878</u>		
7. AGE YEARS <u>61</u>	MONTHS <u>1</u>	DAYS <u>26</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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) <u>Mo</u>		
FATHER	13. NAME <u>Lonnie Drake</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
MOTHER	15. MAIDEN NAME <u>Crooking Baby</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
17. INFORMANT <u>Clarinine Reed</u> (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Central Mem</u> DATE <u>12-18-</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) <u>H. R. Campbell</u> (ADDRESS) <u>867 Washington</u>		
20. FILED <u>12/18</u> 19 <u>39</u> <u>Chas. A. George M.D.</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/14/ 1939

22. I HEREBY CERTIFY, That I attended deceased from 11/16/ 1939, to 12/14/ 1939
 I last saw her alive on 12/14/ 1939. Death is said to have occurred on the date stated above, at 9:40 p.m.
 The principal cause of death and related causes of importance were as follows:
Primary Sarcoma of leg with metastasis Abdominal viscera
 Date of onset 9/1/39

Other contributory causes of importance 53
Chronic myocarditis
Collapsus Gaster

Name of operation Bypass Date of 9/1/39
 What test confirmed diagnosis? Bopsy 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) R. E. Jenkins M. D.
 (Address) 305 1/2 Peabody St.
Springfield 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

W. P. Campbell

....., Registered Apprentice No.....

working under my personal supervision..

Signed *W. P. Campbell*

Licensed Embalmer No. *1747*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X