

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

Do not use this space.

9692

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85  
Township \_\_\_\_\_ Primary Registration District No. 1001  
City St. Joseph, (No. 2515 Jule St.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 400

**2. FULL NAME**

Mollie H. Nell

(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 9 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Timothy F. Nell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 15, 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>80</u>	<u>1</u>	<u>9</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. At Home.  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair Co., Ky.

10. NAME OF FATHER Alexander Hindman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER Margaret Ann Walker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Mrs. C. J. Mitchell  
(Address) 2515 Jule St.

15. FILED MAR 25 1929  
John G. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 24, 1929 19

17. I HEREBY CERTIFY, That I attended deceased from March 19 1929, to March 22 1929, that I last saw her alive on March 22, 1929, and that death occurred, on the date stated above, at 4.43 P.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

82.0 Arteriosclerosis  
27 ischemic (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Apoplexy (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical and laboratory  
(Signed) Blaney M. Fournier, M. D.

3. 25. 1929. (Address) 215 9th Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Somerset, Kentucky DATE OF BURIAL Mar. 27, 1929

20. UNDERTAKER Walter Meierhoffer ADDRESS 1302 Faraon St.

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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