

MAY 25 1934

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

Do not use this space.

13858

1. PLACE OF DEATH

County Putnam Registration District No. 685
Township Buffalo Cal. 1st Primary Registration District No. 5954 B
City 5 (No.) St. Ward (.....)

File No. 23-
Registered No. 18-

2. FULL NAME Mollie Almond Nester

(a) Residence, No. on farm St. Ward.
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Nester</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 12 - 1863</u>		
7. AGE	YEARS	MONTHS
	<u>70</u>	<u>11</u>
		DAYS
		<u>28</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as splainer, sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	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)
Putnam Mo

13. NAME Safith Jefferson Thomas

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

15. MAIDEN NAME Rachael Jackson

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

17. INFORMANT Willard Nester
(ADDRESS) Charabelle Mo. H. B.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Down Cemetery DATE April 22 1934

19. UNDERTAKER W. F. Buda
(ADDRESS) Springfield Mo

20. FILED 4-30 1934 W. H. Treackway
Registrar.

MEDICAL CERTIFICATE OF DEATH

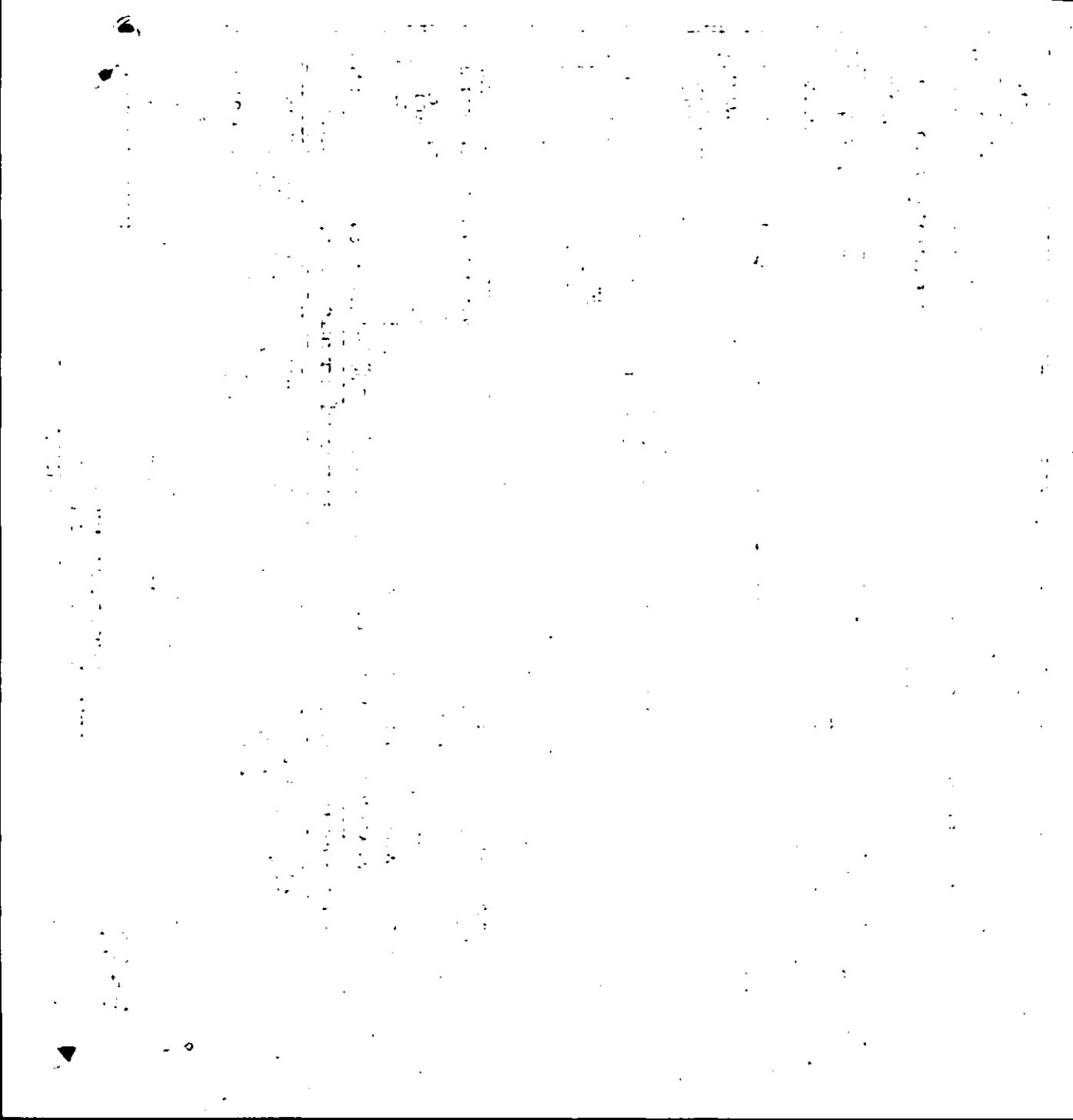
21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20 1934
22. I HEREBY CERTIFY, that I attended deceased from 3-10 1934 to 3-20 1934
I last saw h.e. alive on about 3-20 34 Death is said to have occurred on the date stated above, at 6:15 a.m.

The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
Chronic Hypertension
122 lb
93C
Other contributory causes of importance:
Chronic Hypertension

Name of operation op. for Abdominal Castration Date of 3-15-34
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? no 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 none
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) W. C. Cunningham M. D.
(Address) Lawrence Mo.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Peke

Registration District No. 685

File No. _____

Township Calumet

Primary Registration District No. 290913

Registered No. 25

City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Mollie A. Nestler

(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 7 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

70 11 28

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 spent occup

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)

20. FILED _____ 19 (H. H. Broadway) Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 28 1934

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:

Inverted intestines with adhesions

Name of operation of intestinal obstruction 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) Dr. Curry M. D.

(Address) _____

