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

Do not use this space.

35159

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. ..... St. ..... Ward)

File No. .....

Registered No. 10141

2. FULL NAME Nellie Plant Conrad

(a) Residence. No. 3666 Olive St., N Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 20 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: Dr Wm N Conrad

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 25th 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
68	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER: Samuel Plant
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lancester
(STATE OR COUNTRY) Mass.
12. MAIDEN NAME OF MOTHER: Olive Snow
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Heath
(STATE OR COUNTRY) Mass.

14. INFORMANT: Dr Wm Lightner Conrad
(Address) 3666 Olive St

15. FILED ..... 19 ..... Max C Starkoff
REGISTRAR
OCT 15 1928

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15th 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1928, to Oct 14th, 1928 that I last saw her alive on Oct 14th, 1928, and that death occurred, on the date stated above, at 3 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pancreatitis
120
125
(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
1 DID AN OPERATION PRECEDE DEATH? Yes. DATE OF Oct 9, Expl,
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) Hm Moore, M. D
, 19 (Address) Wall 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: Bellefontaine
DATE OF BURIAL: Oct 16 1928

20. UNDERTAKER: Wagoner U. Co
ADDRESS: 3621 Olive

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.