

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

Do not use this space.

26355

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis* (No. *5215 St. Clair*)

Registration District No. *791*  
Primary Registration District No. *1008*

File No.....  
Registered No. *7571* St. .... Ward)

**2. FULL NAME**

*Felicia Nesselhauf*  
(a) Residence. No. .... St. *9* 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*  
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Joseph Nesselhauf*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 2 1857*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *72 1 20*  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *House wife*  
(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)  
10. NAME OF FATHER *Constantine Strobel*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo* (STATE OR COUNTRY) *Germany*  
12. MAIDEN NAME OF MOTHER *Antonina Schimmer*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany* (STATE OR COUNTRY)

14. INFORMANT *Joseph Nesselhauf* (Address) *5215 St. Clair*  
15. FILED *111* *22* *1929* *May* *St. Louis* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 22 1929*  
17. I HEREBY CERTIFY, That I attended deceased from *July 1* 19*27*, to *July 22* 19*29*, and that that I last saw h. *is* alive on *July 21* 19*29*, and that death occurred, on the date stated above, at *11:45 a. m.*

50 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Chronic MI heart removed 40 yrs ago*  
*Chronic of tonsils and tonsils*  
(duration) yrs. *6* mos. ds.

CONTRIBUTORY *Chronic Myocarditis* (SECONDARY)  
(duration) yrs. *6* mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Place of death*  
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *40 yrs ago*  
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory Report*  
(Signed) *William T. Henschel* M. D.  
*7/29, 1929* (Address) *3000 N. Grand*

\*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 *Calvary* DATE OF BURIAL *July 24 1929*

20. UNDERTAKER *E. J. Schuman* ADDRESS *5215 St. Clair*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

10-1-23-10

