

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

Do not use this space.

23063

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City *St. Louis Mo* (No. *City, Hosp - Curwate*) St. .... Ward)

File No. ....  
 Registered No. **6749**

**2. FULL NAME** *Robert Nevenschwander*

(a) Residence. No. *3111 N. Spring ave.* ..... 10 ..... 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 *Male* 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 *Minnie Nevenschwander*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 14 - 1869*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>58</i>	<i>5</i>	<i>11</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *Switzerland*  
 (STATE OR COUNTRY)

10. NAME OF FATHER *John Nevenschwander*

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

12. MAIDEN NAME OF MOTHER *Don't know*

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

14. INFORMANT *Minnie Nevenschwander*  
 (Address) *3111 N. Spring Ave.*

15. JUL 26 1927. *Mail Starkeoff*  
 FILED 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 25 19 27*

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at *10 - a.m.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic Myocarditis*  
*N. M. C.* (duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) *900* (duration)..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRAINTED? IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY? *yes*  
 WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *A. W. Fath* M. D.  
 7/26 1927 (Address) *Deputy Coroner*  
 \*State the DISEASE CAUSING DEATH, or in (death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Lakewood Park* DATE OF BURIAL *July 27 19 27*

20. UNDERTAKER *By Leidner and Co. N. Market St.*  
 ADDRESS *1417*

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.

DEPARTMENT RECORD

