

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis*

Registration District No. **791**
Primary Registration District No. **1003**
(No. *3837 Labadie Ave*)

File No. **16362**
Registered No. **4402**
St. Ward)

2. FULL NAME

Nellie Heim
(a) Residence. No. *Baptist Hospital 2945 Franklin* St. *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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mr. Heim</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct 20 1886</i>				
7. AGE	YEARS <i>42</i>	MONTHS <i>5</i>	DAY <i>23</i>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Housework</i> (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) *Winchester Ill*

PARENTS	10. NAME OF FATHER <i>Oscar Olavell</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Winchester Ill</i>
	12. MAIDEN NAME OF MOTHER <i>Ella Hankins</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Winchester Ill</i>

14. INFORMANT *Mr Heim*
(Address) *3837 Labadie Ave*

15. *Mar C. Standen*
REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **APR 13 1929** 19
17. I HEREBY CERTIFY, That I attended deceased from *Jan 15 1929* to *April 13 1929*, that I last saw her alive on *April 13 1929*, and that death occurred, on the date stated above, at *1209* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Nephro-nephrosis with large abscess followed with Bacteremia
Erysipelas (duration) yrs. 2 mos. - ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 21 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *At Home*
DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *4-9-29*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Laboratory*
(Signed) *W. W. Harris, M. D.*
H 144, 1929 (Address) 3515 - Mansuad 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 *Walhalla Cemetery* DATE OF BURIAL *4/16 1929*

20. UNDERTAKER *Theo. H. Geiderwider* ADDRESS *1936 St. Louis*

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.

WRITE IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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