

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

Do not use this space.

20793

1. PLACE OF DEATH  
 County St. Louis Registration District No. 789  
 Township Central Primary Registration District No. 60333  
 City St. Louis (No. St. Germain/Kaplan) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Phoebe C. Nagel  
 (a) Residence. No. 6713 Stratford 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 F 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 Nancy L. Nagel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 11 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 4 2 X

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-15-1933

17. I HEREBY CERTIFY That I attended deceased from Aug 30 - 1933, to Sept 15 - 1933 that I last saw her alive on 9-8-1933, and that death occurred, on the date stated above, at 9.06 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral apoplexy left side  
complete hemiplegia of side  
generalized arteriosclerosis  
of the aorta (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY myocardial insufficiency  
 (SECONDARY) hypertension (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? Lab. & Clinical  
 (Signed) Lusk B. Tiernon M. D.  
4-1-1933 (Address) 3718 Jennings

\*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.

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

10. NAME OF FATHER Charles Kumber

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

12. MAIDEN NAME OF MOTHER Phoebe J. Lynt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Charley Nagel (Address) 6713 Stratford

15. FILED 9/16 1933 Archie B. Gray, M.D. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Peter's DATE OF BURIAL 9-7-1933

20. UNDERTAKER L. B. Gammes ADDRESS Natural  
6107 Bridge

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.

1815

