

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in lb	c. CITY OR TOWN St Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis City Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2028 Rutger Street

3. NAME OF DECEASED (Type or print) First Nona Middle Nesselhauf Last			4. DATE OF DEATH Month Dec Day 12 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/2/24	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and state or country) St Louis Missouri	12. CITIZEN OF WHAT COUNTRY U S
13a. FATHER'S NAME Thomas Walsh	13b. MOTHER'S MAIDEN NAME Naomia ?	14. NAME OF HUSBAND OR WIFE William	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT William Nesselhauf 2028 Rutger
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of head, self inflicted in home on Dec. 11, 1960</u> While suffering a temporary mental aberration suicide		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) see above
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20c. TIME OF INJURY Hour ? p.m. Month, Day, Year 12-11-60
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ 11:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>Joseph M. Freeman</i> (Degree or title)	22b. ADDRESS 1200 Clair	22c. DATE SIGNED 12-13-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/16/60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Jefferson Brks Missouri
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24. FUNERAL DIRECTOR Moynell Funeral Home 1926 Allen	25. DATE RECD. BY LOCAL REG. DEC 14 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Halley F. Juelker Jr

Licensed Embalmer No. 4950

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.