No. 2
-1-4-41
-17-39
X28390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED OCT 28 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36177

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 2088

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mount St. Rose O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Nine Months (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 00
(If outside city or town limits, write "RURAL")
(d) Street No. 5620 Kennerly 8
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dr. Wm. J. Willmering
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gladys Mittler
6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased Aug. 9, 1905 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
36	2	3	hr. min.

9. Birthplace St. Louis O (City, town, or county) (State or foreign country)
10. Usual occupation Dentist
11. Industry or business
FATHER
12. Name Wm. Willmering
13. Birthplace Germany 4 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Theresa Ebeling
15. Birthplace St. Louis O Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Gladys Willmering
(b) Address 5620 Kennerly
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15 (Month) (Day) (Year)
(c) Place: burial or cremation ~~XXXXX~~ Calvary
18. (a) Signature of funeral director Wamschurg Und. Co
(b) Address 4746 W. Florissant Ave
19. (a) OCT 13 1941 (Date received local registrar) (b) C. G. McGovern M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12 year 1941 hour 6 minute 5 P M.
21. I hereby certify that I attended the deceased from Sept 3 1933 to Oct. 12 1941; that I last saw him alive on October 12 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary hemorrhage	3 Days
Due to Pulmonary tuberculosis	8 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death) 13 M	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Wm. J. Devine (M. D. or other)
Address 462 No. Taylor Date signed 10/13/41

Dr. DEVINE

(Licensed Embalmer's Statement on Reverse Side)

4622 Taylor
Ks Bourne

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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

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