

FILED FEB 24 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 408

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
3519 Halliday ave.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 37 yrs

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri  
 (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3519 Halliday  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jacob Peter Willen  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month January day 9  
 year 1942 hour 11:45 minute \_\_\_\_\_ 2:30 P.M.

4. Sex Male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Adelo M. Willen  
 6. (c) Age of husband or wife if alive ? years  
 7. Birth date of deceased April 1 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
74 9 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
Coronary Sclerosis  
Arterio Sclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace Clay city Indiana  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired Grain Inspector  
Merchants Exchange

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name John Willen  
 13. Birthplace Clay City Indiana  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Adelo M. Willen  
 (b) Address 3519 Halliday ave.  
 17. (a) Removal (b) Date thereof Jan. 11, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Clay City, Indiana

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? \_\_\_\_\_

18. (a) Signature of funeral director W. J. Anderson  
 (b) Address 7814 S. Broadway  
 19. (a) JAN 14 1942 (b) \_\_\_\_\_  
(Date received local registry) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature Alfred Perry (M, D. or other)  
 Address \_\_\_\_\_ Date signed 1/12/42

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

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**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 *Louis C. Hoffmeister*  
Licensed Embalmer No. *3871*  
P. O. Address *7814 S. Broadway*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**  
**If this body is not embalmed, fact should be so stated above.**