

No. 2
21/47
17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED APR 5 1948

Registration District No. 3787

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

11153

State File No.

Primary Registration District No. 6076

Registrar's No. 767

1. PLACE OF DEATH:

(a) County..... St. Louis
(b) City or town..... Ferguson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1351 Chambers Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... St. Louis
(c) City or town..... Ferguson 7/6
(If outside city or town limits, write "RURAL")
(d) Street No..... 1351 Chambers Rd.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... Rose Willmann

3. (b) If veteran, name war..... None
3. (c) Social Security No. None

4. Sex..... Female 5. Color or race..... White
6. (a) Single, widowed, married, divorced..... Widowed
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... September 19 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 2 hr. min

9. Birthplace..... St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation..... House Work

11. Industry or business.....

12. Name..... Hy Pauly

13. Birthplace..... Germany
(City, town, or county) (State or foreign country)

14. Maiden name..... Anna Wormann

15. Birthplace..... U. S. A.
(City, town, or county) (State or foreign country)

16. (a) Informant..... Wayne Willmann

(b) Address..... 1351 Chambers Rd.

17. (a) Burial (b) Date thereof..... 3-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... St. Peters Cemetery

18. (a) Signature of funeral director..... Math. Hermann & Son, Inc.
(b) Address..... 2161 E. Fair Ave.

19. (a) 3-23-48 (b) Carolyn Slapnick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... March day 21
Year..... 1948 hour..... 9 minute..... 30 P. M.

21. I hereby certify that I attended the deceased from
Dec. 19 1944 to March 21 1948
that I last saw her alive on March 21 1948
and that death occurred on the date and hour stated above
Immediate cause of death..... Pulmonary Edema
Durgston

Due to..... Cerebral Hemorrhage
Arterio Sclerosis
Due to..... Chronic Ence Carditis
Other conditions..... (Mitral Ins.)
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... 920
Of autopsy.....

PHYSICIAN
Underline the cause of 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?.....

White at work?..... (Specify type of place)
Means of injury.....

23. Signature..... W. J. Harris M.D. or other
Address..... 4548 Harris Dr. Date signed..... 3/22/48

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

MOTHER FATHER

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

Ernest W. Spillars

Licensed Embalmer No. *4080*

P. O. Address _____

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.

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Rose Wellman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 19 1900
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 0 If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 2 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-11153