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

Do not use this space.

31873

1. PLACE OF DEATH

County ..... Registration District No. 701 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9235

City St. Louis Mo. (No. Christian Hosp ..... St. ..... Ward)

2. FULL NAME HELEN WILLEMS

(a) Residence. No. 2944a Greer St., 10 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Jacob Willems

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6 - 1863

7. AGE Years 64 Months Days 9 If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER Charles Willems
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Augusta Klee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Jacob Willems
(Address) 2944a Greer Ave

15. FILED OCT 17 1927 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15 27

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 19 to Oct 5th 19 27 that I last saw her alive on Oct 5th 19 27, and that death occurred, on the date stated above, at 7 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of heart
Myocarditis: Chronic
Pericardial effusion
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Empyema Gall Bladder
(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 2944 Greer Ave
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Xray Gall Bladder
(Signed) Arthur Endlaes, M. D
10/17, 1927 (Address) 2202 Kennedy St

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Florissant Mo Sacred Heart Cemetery
DATE OF BURIAL Oct 18 27 19

20. UNDERTAKER Stuart Carroll
ADDRESS 4600 Natl 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.