

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

Do not use this space.

3496

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **Christian Hospital**) St. _____ Ward _____
 Registered No. **1137**

2. FULL NAME

Charles John Willmann
 (a) Residence. No. **2131 Holdrege** St., **10** Ward. **Jennings Mo.**
 (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

2. SEX *Male* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Single*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 30 1927*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1	
				day, hrs.	or min.
			<i>29</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER *John H. Willmann*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Benton Co Mo*

12. MAIDEN NAME OF MOTHER *Heta Nommensen*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

14. INFORMANT *John H. Willmann*
 (Address) *2131 Holdrege*

15. FILED *JAN 31 1928* *Max G. Starkeoff*
 19... Registrar

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 29 1928*

17. I HEREBY CERTIFY, That I attended deceased from *1-28-28* to *Jan 29 1928*, and that I last saw him alive on *Jan 29, 1928*, and that death occurred, on the date stated above, at *4:40 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity 119 B
Enterocolitis 158
11 B B 158
 (duration) yrs. mos. ds. *29 ds.*
CONTRIBUTORY (SECONDARY) *Atresia*
 (duration) yrs. mos. ds. *21 ds.*

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH:.....

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
20. WAS THERE AN AUTOPSY? *no*
21. WHAT TEST CONFIRMED DIAGNOSIS? *Dr. Robert M. D.*
 (Signed) *1/30, 1928* (Address) *718 Beaumont Bldg*

*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 *New Bethlehem* **DATE OF BURIAL** *Jan 31 1928*

20. UNDERTAKER *Theo. H. Biederwieser* **ADDRESS** *1936 St. Louis Ave*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

