

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

Do not use this space.

23447

1. PLACE OF DEATH

County..... Registration District No. 79R / 100S
 Township..... Primary Registration District No.
 City St. Louis (No. 3948) W. Flourissant St. ave (Ward)

2. FULL NAME Lorraine Willmering

(a) Residence. No. 4532 Geraldine St. 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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 21 - 1917</u>		
7. AGE <u>12</u>	YEARS <u>5</u>	MONTHS <u>8</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>school girl</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

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

10. NAME OF FATHER Garry J. Willmering
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Chaele Vinton
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY)

14. INFORMANT Harry Willmering
 (Address) 4532 Geraldine Ave

15. FILED -1, 1929 May 21 St. Louis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1929

17. I HEREBY CERTIFY, That I attended deceased from 2, 1929 to 9 that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at 2:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Burns - 3rd degree received in a fire and explosion caused by fire, words becoming CONTRIBUTORY (SECONDARY) ignited - accident

18. WHERE WAS DISEASE CONTRACTED 110
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

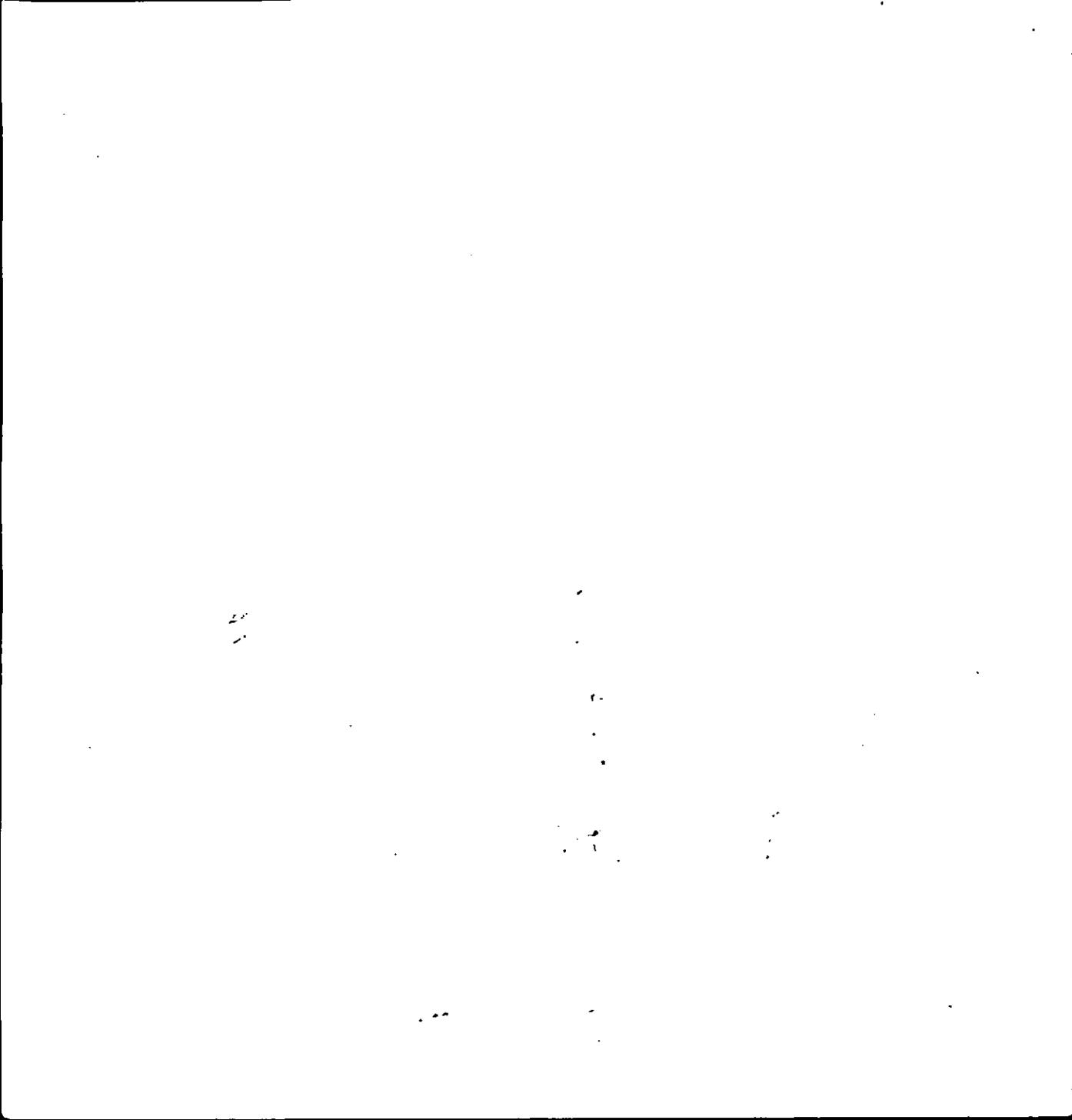
(Signed) Wm V. Dwyer M.D.

. 1929 (Address) Coroner

*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 Calvary DATE OF BURIAL July 2, 1929

20. UNDERTAKER Parsonsburg Mch. Co ADDRESS 4740 St. Flourissant



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 291 File No. 6932
 Township St. Louis Primary Registration District No. 1003 Registered No. 6932
 City St. Louis (No.) St. Ward

2. FULL NAME

(a) Residence. No. St. 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED SEP 10 1929 Max C. Starbuck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... all on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Burns 3rd degree
Building burned
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. W. Kenna M.D. 39
9/10, 1929 (Address) Dep. Comm.

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23447