

MAR 24 1934

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

Do not use this space.

## 1. PLACE OF DEATH

County St. LouisRegistration District No. 790File No. 6387Township CentralPrimary Registration District No. 6033 ARegistered No. 64City Clayton - R.R. # 2No. 2

St. \_\_\_\_\_ Ward)

## 2. FULL NAME

(a) Residence, No. Peter Willi, St. \_\_\_\_\_ Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mo. da.How long in U. S., if of foreign birth? 55 yrs. mo. da.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <u>Katherine Willi</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug-16-1861</u>		
7. AGE	YEARS <u>72</u>	MONTHS <u>6</u>
	DAYS <u>8</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired farmer</u>	11. Total time (years) spent in this occupation <u>55</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Own farm</u>	
	10. Date deceased last worked at this occupation (month and year) <u>1922</u>	
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Switzerland</u>	
	13. NAME <u>Otto Willi</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Switzerland</u>	
	15. MAIDEN NAME <u>Frances Bieder</u>	
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Switzerland</u>	
	17. INFORMANT <u>Mrs. Katherine Willi</u> (ADDRESS) <u>Clayton Mo</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Lake Charles</u> DATE <u>Feb-27-34</u>		
19. UNDERTAKER (ADDRESS) <u>Schneider and Co</u> <u>St. Louis</u>		
20. FILED <u>2/26</u> 19 <u>34</u> <u>John H. Mendenhall</u> Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb-24, 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1934, to Feb 24, 1934.  
I last saw him alive on Feb 24, 1934. Death is said to have occurred on the date stated above, at 1:25 PM.  
The principal cause of death and related causes of importance were as follows:  
Pneumonia  
Date of onset 2/22/34  
It was in a weakened senile condition and suffering from other causes as follows:  
Other contributory causes of importance:  
ulcerating left leg, arterio-sclerosis and hypertensive

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? chest Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) Charles T. Kottal, M. D.  
(Address) 855 Century Bldg  
St. Louis, Mo

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.

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including names and dates. The text is mostly obscured by noise and low contrast.]

**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. 998

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 6033A

Registered No. 64

City Clayton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Peter Willi

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 Robert J. Ambuster Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 24 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (Date of onset \_\_\_\_\_)

Sobar

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY

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.

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

