DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37289

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 164

1. PLACE OF DEATH:

(a) County Saline. /

(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Fitzgibbons Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Nine Days (Specify whether
In this community Fifty Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: /

(a) State Slater (b) County Saline

(c) City or town Slater Mo
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gustav Edward Willming 455

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ricka

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased February-27-1857
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
82	7	11	hr. min.

9. Birthplace Franklin County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Gustav Willming 6
13. Birthplace Solinger Germany 6
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Henrietta Brensing
15. Birthplace Berghausen Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C H Willming
(b) Address Slater Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof Oct-9-39
(Month) (Day) (Year)
(c) Place: burial or cremation Slater City Cemetery

18. (a) Signature of funeral director Jones & Salzer
(b) Address Slater Mo.

19. (a) 10-11-39 (Date received local registrar) (b) Mary Kent Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8-39.
year 1939 hour 9.52 PM minute 52 M.

21. I hereby certify that I attended the deceased from Oct 8, 1939, to Oct 9, 1939;
that I last saw him alive on Oct 8, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	5 days
Due to	
Due to Chr. Myocarditis	?
Other conditions Chr. Nephritis	?
(Include pregnancy within 3 months of death)	

Major findings:
Of operations 131
Of autopsy

PHYSICIAN
Underline the cause to 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? No
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address Marshall Mo Date signed 10/11/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 8-17-39 I X19511

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/18/39

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.....

Licensed Embalmer No. 3143

P. O. Address Slater Mo

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, above space should be left blank.