

6-2
4-41
7-38
X28390

AUG 8 1941
Registration District No. **104**

Primary Registration District No. **104**

Registrar's No. **1605**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Ferguson**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
328 Suburban Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Ferguson** (If outside city or town limits, write "RURAL")
(d) Street No. **328 Suburban Ave**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Rosa Elizabeth Will**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Fred Carl Will** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 7 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 2 23 hr. min.

9. Birthplace **St. Louis County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business

12. Name **Jaacob Kropp**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Christine Orth**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Margaret Fred Will**
(b) Address **328 Suburban Ave Ferguson, Mo**

17. (a) **Burial** (b) Date thereof **8/2/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elm Lawn Cem.**
18. (a) Signature of funeral director **Louis H. Bopp, Inc.**

(b) Address **Kirkwood, Mo.**
19. (a) **JUL 31 1941** (Date received local registrar)
E. M. Lawrence, M.D. (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30**
year **1941** hour **9:10PM** minute _____ M.

21. I hereby certify that I attended the deceased from **June 30** 19**41** to **July 7** 19**41**
that I last saw her alive on **July 7** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death
apoplexy
arterial hypertension
sluggish liver
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations **S. A. I.**
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. W. Simms** (M. D. or other) **W**
Address **4559 Cedar** Date signed **7-31-41**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *John M. Meyer*
Licensed Embalmer No. *3288*
P. O. Address *Wickwood, Ind.*

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, fact should be so stated above.