

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 6 1945

Registration District No. 117

Primary Registration District No. 5436

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Rural - Boulevard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Albert B. Schneider Res.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community entire life
years, months or days

3. (a) PRINT FULL NAME MARY ANNA WILLMS

3. (b) If veteran, name war No 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 _____ 16. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 20 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 3 12 hr. min.

9. Birthplace Gasconade County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Housekeeping

12. Name Fred W. Held

13. Birthplace -0- Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Wattenberg

15. Birthplace -0- Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Albert B. Schneider

(b) Address Hermann, Mo. RFD #1

17. (a) Burial (b) Date thereof 5/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cem. Bay, Mo

18. (e) Signature of funeral director Paul H. Blumer

(b) Address Hermann Mo

19. (a) 5-14-45 (b) Mrs. F. B. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
RURAL
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 2 Miles North of Bay, MO
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -0-

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1945 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from From April 10, 1945 to May 12, 1945
that I last saw her alive on May 12 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocarditis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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 E. Rhodius (M. D. or other) _____

Address Hermann Mo Date signed 5/13/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

6-5-45

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

Chas. H. Pope

Licensed Embalmer No. 2552

P. O. Address *Hermann, 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, fact should be so stated above.