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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1947
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

11712
State File No. _____
Registrar's No. 3343

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis MO
(c) Name of hospital or institution: Alexian Bros Hospital
(d) Length of stay: 3 days
In this community 73 years, months or days

3. (a) PRINT FULL NAME: Joseph W. Willmann
3. (b) If veteran, name war. no
3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced. married
6. (b) Name of husband or wife: Marguerite Gravemann
6. (c) Age of husband or wife if alive: 43 years
7. Birth date of deceased: February 7th, 1864

8. AGE: Years 73 Months 1 Days 19
If less than one day hr. _____ min. _____

9. Birthplace: St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: Insurance Broker

11. Industry or business: General Insurance

12. Name: John Willmann
13. Birthplace: Germany

14. Maiden name: Mary Richert
15. Birthplace: St. Louis Mo

16. (a) Informant: Marguerite Willmann
(b) Address: 4130 Nebraska Ave.

17. (a) Burial (b) Date thereof: Mar. 29, 1947
(c) Place: burial or cremation: Valley Cemetery

18. (a) Signature of registrar: _____
(b) Address: 28 28 1847

19. (a) MAR 28 1947 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: _____
(c) City or town: St. Louis
(d) Street No. 4130 Nebraska Ave.
(e) Citizen of foreign country? no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 26th day March year 1947 hour 7 minute 15 P.M.
21. I hereby certify that I attended the deceased from June 29, 1944 to March 5, 1947
that I last saw him alive on March 5, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: chronic thrombotic myocarditis
Due to: _____
Due to: _____
Other conditions: chronic nephritis

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? _____
(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: _____ (M. D. or other) _____
Address: 3808 Broadway Date signed: 3/27/47

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

000
17
159
3

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

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 *Henry M. Brammer*

Licensed Embalmer No. *4200*

P. O. Address.....

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.