

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10837

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2333

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ohio b. COUNTY 977	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cleveland 33	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 8118 Decker Ave. 2	
3. NAME OF DECEASED a. (First) Julia		b. (Middle) Willkomm	
c. (Last) Willkomm		4. DATE OF DEATH (Month) (Day) (Year) 3 13 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 30, 1878
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany 4
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME ? Spross	
13b. MOTHER'S MAIDEN NAME Don't Know		14. NAME OF HUSBAND OR WIFE Herman Willkomm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS Herman Willkomm 1093 E. 71st St. Cleveland Ohio	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock ANTECEDENT CAUSES DUE TO (b) Intestinal Obstruction DUE TO (c) Strangulated Ventral Hernia, 4 days II. OTHER SIGNIFICANT CONDITIONS None 12/20/48 Interval between onset and death 4 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No operation 12/20/48	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) 5605 (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 3-12, 1949, to 2-10, 1949 that I last saw the deceased alive on 3-12, 1949 and that death occurred at 7:30 P.M., from the causes and on the date stated above.	
23a. SIGNATURE E. Lee Shrader M.D. (Degree or title)		23b. ADDRESS 3720 Washington	
23c. DATE SIGNED 3/4/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 3-14-1949		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Cleveland, Ohio		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 14 1949 J. B. Isater		ADDRESS Weick Bro. Und. Co. 2201 S. Grand Bl	

(Licensed Embalmer's Statement on Reverse Side)

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

300

M...

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *James R. Dunn*
Licensed Embalmer No. 4527

P. O. Address 2201 S Grand

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.