

FILED APR 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14306  
3278  
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 5475 Cabanne	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Raymond	b. (Middle) John	c. (Last) Wille	4. DATE OF DEATH (Month) (Day) (Year)
				April 9, 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 16, 1892	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Days 11	IF UNDER 2 HRS. Hours 23
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. Manager	10b. KIND OF BUSINESS OR INDUSTRY Dolan Real Estate Co.	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Francis B. Wille	13b. MOTHER'S MAIDEN NAME Wilhelmina Boedecker	14. NAME OF HUSBAND OR WIFE Katherine Wille
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) World War I	16. SOCIAL SECURITY NO. 498-03-7883	17. INFORMANT'S SIGNATURE OR NAME Katherine Wille	ADDRESS 5475 Cabanne
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cirrhosis of Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Mar. 1, 1949</i> <i>Nov. 5, 1948</i> <i>2 days</i> <i>20 min</i>
	ANTECEDENT CAUSES (b) <i>Acute respiratory infection</i>		
	II. OTHER SIGNIFICANT CONDITIONS (c) <i>Parasitosis &amp; extreme drainage</i> <i>Re-attack to blood transfusion</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 1944, to Apr 9, 1949, that I last saw the deceased alive on Apr 9, 1949, and that death occurred at 6 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Mrs M. Davis M.D.</i> (Degree or title)	23b. ADDRESS 24227 Grand	23c. DATE SIGNED 4/11/49.
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-13-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 12 1949 <i>J. B. Sasser</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. F. Stuart</i>	ADDRESS 1125 25th Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10-48

MAY 23 1949

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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.

Signed..... *Robert McNeary*

Signed.....

Student Embalmer

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

**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.