

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 12 1940

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: 2
(a) County _____
(b) City or town 4554a Fair Ave. St. Louis
(c) Name of hospital or institution:
4554a Fair Ave.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary A. Welsch 420
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles A. Welsch 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased About 1875
(Month) (Day) (Year)

8. AGE: Years About 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Unland 6
13. Birthplace Germany
14. Maiden name Carolyn Boever
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
(b) Address 4554a Fair Ave.

17. (a) Burial (b) Date thereof 1/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]
(b) Address 2117 E. Grand Blvd.

19. (a) [Signature] (b) [Signature]
(Date signed) (Signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St. Louis 9
(d) Street No. 4554a Fair Ave.
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 28
year 1939 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Dec. 27th
to Dec. 28th, 1939, that I last saw h. Y. alive on Dec. 28th, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Obital Haemorrhage causing a Hemiplegia. (Non Traumatic) Due to Arterial Tension.
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy None
PHYSICIAN _____ Underline the cause to which death should be charged statistically.

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? _____

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

23. Signature [Signature] (M. D. certifier) _____ Address 4244 W. Florissant Date signed 12/29/39

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.....

Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 12117 E. Blvd

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, above space should be left blank.