

FILED APR 6 1946

Registration District No. **209**

Primary Registration District No. **3043**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Spanning**
(c) Name of hospital or institution: **Spanning Hospital (1)**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis** ⁰⁰⁹
(c) City or town **St. Louis** ⁹
(If outside city or town limits, write "RURAL")
(d) Street No. **2507 North Market** ¹
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Carolyn Welch**

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 **Single (1)**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased **February** **6** **1946**
(Month) (Day) (Year)

8. AGE: Years **x** Months **x** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Spanning** **Missouri (1)**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Charles Welch** **Kansas (1)**
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name **Eula Spigge**
15. Birthplace **Missouri (1)**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Welch**
(b) Address **507 North Market St., St. Louis, Mo.**

17. (a) **Burial** (b) Date thereof **3/16/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grand Union Burial Park**

18. (a) Signature of funeral director **Jos. G. Bonnell**
(b) Address **Spanning, Mo.**

19. (a) **2-27-46** (b) **Dr. E. M. Lucke**
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **16** year **1946** hour _____ minute **4:10** P.M.
21. I hereby certify that I attended the deceased from **2-6** to **2-16** 19 **46**
that I last saw him alive on **2-16** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Tub. pneumonia**
Due to **Tub. (mother had severe pre-existing Tub. pneumonia)**

Duration **10 d**

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

Major findings: Of operations **10**
Of autopsy _____

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? _____ (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 **0**

23. Signature **Howard Sudril** (M. D. or other) **MD**
Address **Spanning, Mo.** Date signed **2-27-46**

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

9003

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..... *H.M. O'Donnell*

Licensed Embalmer No. *3889*

P. O. Address..... *Hannibal, 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.