

FILED APR 27 1949

STANDARD CERTIFICATE OF DEATH

State File No. 14276  
3419

318

1003

No. 300  
10-48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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

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. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17
d. FULL NAME OF HOSPITAL OR INSTITUTION 3309 Minnesota			d. STREET ADDRESS (If rural, give location) 3309 Minnesota		
3. NAME OF DECEASED (Type or Print) Katherine		a. (First)	b. (Middle)	c. (Last) Welscher	4. DATE OF DEATH (Month) (Day) (Year) 4/14/49
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 7, 1869	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY --			
13a. FATHER'S NAME Fred Schuermann		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Louis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter Welscher--3309 Minnesota		
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)  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) Coronary Sclerosis DUE TO (c) Arteriosclerosis  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 946		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:59 a.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/16/49	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 16 1949 J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Weldale 3634 Gravois				

**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 Robert Wheeler.....

Licensed Embalmer No. 2128.....

P. O. Address Wheeler (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.

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