

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1955

State File No. **35269**
Registrar's No. **8851**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 3 yrs 9 mo.	c. CITY OR TOWN St. Louis, Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5800 Arsenal St.	
3. NAME OF DECEASED a. (First) George		b. (Middle) Vernon	
c. (Last) Welch		4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1955	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower	8. DATE OF BIRTH 5-30-1881
9. AGE (In years last birthday) 74		10. KIND OF BUSINESS OR INDUSTRY Pipe Fitter	11. BIRTHPLACE (City and State or Foreign Country) ✓ Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Thomas Welch	
13b. MOTHER'S MAIDEN NAME Annie Payne		14. NAME OF HUSBAND OR WIFE Jennie Sullivan	
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. 491-18-2226	
17. INFORMANT'S SIGNATURE OR NAME Hospital Records		ADDRESS	
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) Rupture Left Ventricle with Cardiac Tamponade ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Thrombosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.1	
20. AUTOPSY? YES <input checked="" 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 Dec. 27, 1951 , to Oct. 7, 1955 , that I last saw the deceased alive on Oct. 7, 1955 , and that death occurred at 10:55A.M. , from the causes and on the date stated above.			
23a. SIGNATURE George M. Janke, M.D.		23b. ADDRESS 5600 Arsenal	
23c. DATE SIGNED Oct. 8, 1955			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 10-11-55	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. OCT 11 1955		25. FUNERAL DIRECTOR'S SIGNATURE Cullen & Kelly	
REGISTRAR'S SIGNATURE [Signature]		ADDRESS 7267 Natural Bridge	

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 Not Embalmed....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James A. Lamme.....
Licensed Embalmer No. 414

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.