

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027535

FILED VS AUG 17 1959

317

544

2147

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u>	Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>ARNOLD</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>P.O. Box 69</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>LEROY</u> Last <u>WELSH</u>			4. DATE OF DEATH Month <u>AUG.</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1924</u>	9. AGE (last birthday) <u>34</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>9</u> Days <u>2</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIO ENG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.B.C. RADIO STA.</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>LEROY WELSH</u>		13b. MOTHER'S MAIDEN NAME <u>NELLIE PYLE</u>		14. NAME OF HUSBAND OR WIFE <u>ROSALIE WELSH</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W. No 2</u>	16. SOCIAL SECURITY NO. <u>487-20-2233</u>	17. INFORMANT Address <u>Box 69 MRS ROSALIE WELSH ARNOLD Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>		<u>1 minute</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Enlarged Heart</u>	<u>3 months</u>
	DUE TO (c) <u>Arterial Sclerotic Heart Disease</u>	<u>3 months</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bicuspid aortic A/a</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>11/157</u> to <u>8/6/59</u> and last saw him alive on <u>8/6/59</u> . Death occurred at <u>6</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Charles Burnside M.D.</u>	22b. ADDRESS <u>206 W Argonne Richmond</u>	22c. DATE SIGNED <u>8/9/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>Aug-10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MISSOURI CREMATORY</u>
24. FUNERAL DIRECTOR ADDRESS <u>FEY FUNERAL HOME, MEHLVILLE Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Missouri</u>

25. DATE RECD. BY LOCAL REG. <u>8-9-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gustav W. Duta

Licensed Embalmer No. 43

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.