URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-013375
STATE FILE NUMBER

FILED VS MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3141

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis City Hosp. #1
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4922 McPherson
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: William; Middle: ; Last: Welch
4. DATE OF DEATH: Month: March; Day: 16; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 12/23/1896
9. AGE (last birthday): 63
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HR: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: William Welch
13b. MOTHER'S MAIDEN NAME: Anne Horn
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Catherine Alexander, 4922 McPherson
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) TERMINAL RENAL DISEASE
DUE TO (c) ADVANCED CARCINOMA OF BLADDER
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 181.0
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [X] No [ ] Unknown
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 2-26-60 to 3-16-60 and last saw her/him alive on 3-16-60
Death occurred at 1:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: J. H. Schneider (Degree or title) M.D.
22b. ADDRESS: 1515 Lafayette Ave.
22c. DATE SIGNED: 3-16-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-17-60
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Bevier, Mo.
24. FUNERAL DIRECTOR: Albert H.Hoppe, Inc., ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: MAR 17 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.