

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City St. Louis

Registration District No. 791

Primary Registration District No. 1003

File No. 42860

Registered No. 10535

(NO. 5601 Delmas ave St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Nancie Bancroft Welles.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

DATE OF BIRTH July 11 1896
(Month) (Day) (Year)

AGE 85 yrs. 4 mos. 16 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none 0-0

BIRTHPLACE (City or town, State or foreign country) Westfield mass.

NAME OF FATHER Brancord Root

BIRTHPLACE OF FATHER Westfield mass.
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Anna maria Bancroft

BIRTHPLACE OF MOTHER Westfield mass.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E Pullen
(ADDRESS) 5437 Page ave

Filed DEC - 3 1916 Max C. Starkloff
REGISTRAR

25 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 28 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 9th, 1916, to Nov. 28th, 1916, that I last saw her alive on Nov. 27th, 1916, and that death occurred, on the date stated above, at 11 'Stm.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis + organic disease of heart
95 yrs
77 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Rothelle Funkhouser M. D.
Nov 29 1916 (Address) 4354 Olive St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Bellefontaine

DATE OF BURIAL

Dec 1 1916

UNDERTAKER

M. H. Alexander

ADDRESS

2835 Olive

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

