LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

6094

1. PLACE OF DEATH

County ..... Registration District No. 10 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1774

City St Louis Mo. (No. ..... Sanitarium St. ..... Ward)

2. FULL NAME Michael Welmering

(a) Residence. No. 2904 Wyoming St., 3 Ward (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 17 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Della Welmering

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 30, 1885

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
39	4	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer: "

9. BIRTHPLACE (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN): "
(STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): "
(STATE OR COUNTRY): New Jersey

14. INFORMANT: Harry Grant
(Address) 5400 Arsenal

15. FILED ....., 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 16 1925

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1924, to Feb 16, 1925 that I last saw him alive on Feb 16 1925, and that death occurred, on the date stated above, at 6:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dementia Paralytica

(duration) ..... yrs. 4 mos. + ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF ——

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory Clinical

(Signed) Harry Grant, M. D

2-16, 1925 (Address) 5400 Arsenal

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cem
DATE OF BURIAL: Feb 18 1925

20. UNDERTAKER: Thomas J. Finnie
ADDRESS: 1 Grand

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.

WHITE PEARLEY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?..... .....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)..... , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.