

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

Do not use this space.

22374

1. PLACE OF DEATH

County.....
 Townsh.....
 City.....
 Registration District No. **791**
 Primary Registration District No. **1008**
 (No. **3408 N. 14**)

File No.....
 Registered No. **6563**
 St..... Ward.....

2. FULL NAME

Charles Welsch
 (a) Residence. No. **3408 N. 14** St., **26** Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (or) WIFE OF *Mary E Mermemeyer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 12 1885*

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
76 4 8

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

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

10. NAME OF FATHER *Do Not Know*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Do Not Know*

12. MAIDEN NAME OF MOTHER *Do Not Know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Do Not Know*

14. INFORMANT *Chas Welsch*
 (Address) *3408 N. 14*

15. FILED *22 1928*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-20-1928*

17. I HEREBY CERTIFY That I attended deceased from *May 20* to *June 20* 19*28*
 that I last saw h. alive on *June 25*, 19*28* and that death occurred, on the date stated above, at *10:45 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic cerebral Hemorrhage

CONTRIBUTORY *Chronic Interstitial*
 (SECONDARY) *degenerations of the kidneys*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *Ill*
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *Benjamin F. Theuer* M. D.
 (Address) *1901 Madison*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary Cem*
DATE OF BURIAL *6/23 1928*

20. UNDERTAKER *W. A. Stock*
ADDRESS *2117 E Grand*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

