

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

Do not use this space.

14763

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis, Mo. (No. City Hospital #1)

File No. ....  
 Registered No. 4172  
 St: ..... Ward)

**2. FULL NAME** William L. Welsh

(a) Residence. No. 1909 Lynch Street St. 23 Ward. (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 <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Married</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Nora Welsh</b>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>February 21st, 1905</b>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<b>25</b>	<b>2</b>	<b>3</b>	

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

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

10. NAME OF FATHER **James Wm. Welsh**  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Randall County Illinois**  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER **Lena Vollmer**  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Greenfield Ill**  
 (STATE OR COUNTRY)

14. INFORMANT Nora Welsh  
 (Address) 1909 Lynch Street

15. FILED APR 25 1930 May C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 24th, 1930**  
 17. The Physician in attendance 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 **8:00 P.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebellar Hemorrhage  
(Non-traumatic)  
82A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 74 wt (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....  
 WAS THERE AN AUTOPSY? 3

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) [Signature] M.D.  
4/25, 1930 (Address) 10 Deputy Coroner

\*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 Vollmer Home DATE OF BURIAL **Apr. 29 1930**

20. UNDERTAKER Wacker-Heldrich ADDRESS **2331 S. Brdwy.**

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.

