

FEB 16 1938

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

4100
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 96
 (b) Township St. Louis Primary Registration District No. St. Marys Hospital Registered No. 115
 (c) City Richmond Heights, Mo. (d) Street No. St. Marys Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 26. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Martin J. Welsch 420
 (a) Residence, No. NR Waterloo, Illinois St. NR
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 16th, 1938

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

22. I HEREBY CERTIFY That I attended deceased from December 20, 1937 to January 16, 1938
 I last saw him alive on January 16, 1938. Death is said to have occurred on the date stated above, at 11:15 A.M.
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20th, 1904
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33 5 25

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Manager
 9. Industry or business in which work was done, as saw mill, bank, etc. Oil Company
 10. Date deceased last worked at this occupation (month and year) October 1937 11. Total time (years) spent in this occupation 4 Yrs

Uremia -
Glomerular nephritis
Arterio-sclerosis
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mayestown Illinois

Other contributory causes of importance:
Glomerular nephritis
Arterio-sclerosis

FATHER 13. NAME Joseph Welsch
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mayestown, Illinois

Name of operation X Date of X
 What test confirmed diagnosis? X Was there an autopsy yes

MOTHER 15. MAIDEN NAME Mary Bertram
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fults, Illinois

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? X Date of injury X, 1938
 Where did injury occur? X (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) Ruth Welsch Waterloo, Illinois

Manner of injury X
 Nature of injury X

18. BURIAL, CREMATION, OR REMOVAL PLACE Waterloo, Ill. DATE January 18, 1938

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify X

19. FUNERAL DIRECTOR (ADDRESS) Albert H. Hoppe Inc., 429 N. Euclid Avenue

(Signed) Romualdo M. D.
 (Address) 3720 Washington

20. FILED 1 - THEODORE R. MEYER M. D., Local Registrar

GRADE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

132a

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signed

Albert H. Hoyle

Licensed Embalmer No. *1861*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

4100

Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 284
 (b) Township _____ Primary Registration District No. 111 Registered No. _____
 (c) City Richmond Hts (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Martin J. Welsh

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
	<u>33</u>	<u>5</u>	<u>25-</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-17 1935 T.R. [Signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15-1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

suppuration
131
 Other contributory causes of importance:
glomerular nephritis
chronic
hypertension -

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) R.O. [Signature], M. D.
 (Address) 3720 Washington

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1938
S-4100