

#797

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

17111
Do not use this space.

JUN 12 1939

1. PLACE OF DEATH

(a) County St. Louis MO Registration District No. 1008
(b) Township _____ Primary Registration District No. _____ Registered No. 4645
(c) City St. Louis MO (d) Street No. Hammer A. 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 416 Great West Welford St. 21
2120 Chestnut (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 11, 1904
7. AGE YEARS 34 MONTHS 9 DAYS 7 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Johannes
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) Arkansas

FATHER 13. NAME Alfred Welford

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

MOTHER 15. MAIDEN NAME Isabella M. Entock

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

17. INFORMANT Katie Welford (ADDRESS) 2120 Chestnut, St

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington PK DATE May 22 1939

19. FUNERAL DIRECTOR (NAME) English Und. Co. (ADDRESS) 2931 Lucas, ave

20. FILED MAY 22 1939 J. B. Budeck Local Registrar

MEDICAL CERTIFICATE OF DEATH
No attending physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18, 1939

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 7:10 P.M.

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

Chronic Myocarditis; Broncho Pneumonia; Chronic Interstitial Nephritis with multiple cortical cysts. (non-malignant)

Date of onset

Other contributory causes of importance:

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Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

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 see above

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Alfred Perry M. D.

(Address) St. Louis, Mo

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, *M. L.*

Louis V. Atkins, or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Louis V. Atkins

Licensed Embalmer No.

2842

P. O. Address

3644 Finney

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

If this body is not embalmed, above space should be left blank.