

STANDARD CERTIFICATE OF DEATH

State File No. 4985

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 1815

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS, MISSOURI
(c) Name of hospital or institution BARNES HOSPITAL
(d) Length of stay: In hospital or institution 55 days
In this community 55 days

3. (a) PRINT FULL NAME ALBERT CHARLES WELGE
3. (b) If veteran, name war no
3. (c) Social Security Not maintainable

4. Sex Male 5. Color or race White
6. (a) Single, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr 8 1910

8. AGE: Years 29 Months 10 Days 13
If less than one day hr. _____ min. _____

9. Birthplace Chester Illinois

10. Usual occupation Criminalologist

11. Industry or business Illinois Penitentiary

12. Name William Welge

13. Birthplace Chester Illinois

14. Maiden name Elera Gilster

15. Birthplace Chester Illinois

16. (a) Informant William Welge

(b) Address Chester Ill

17. (a) Removal (b) Date thereof 2 22 1940

(c) Place: burial or cremation Chester Illinois

18. (a) Signature of funeral director Welge Bros

(b) Address Chester Ill

19. (a) FEB 23 1940 (b) J.F. Budick

2. USUAL RESIDENCE OF DECEASED:
(a) State ILLINOIS (b) County _____
(c) City or town CHESTER
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month FEBRUARY day 21
year 1940 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from DECEMBER 28, 1939 to FEBRUARY 21, 1940
that I last saw him alive on FEBRUARY 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death agranulocytosis
Subacute bacterial endocarditis

Due to rheumatic heart disease

Due to _____

Other conditions _____

Major findings: subacute bacterial endocarditis
Of autopsy Rheumatic heart disease

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (e) Means of injury _____

23. Signature F.R. Bradley (M. D. or other) _____
Address BARNES HOSPITAL Date signed _____

NR

Duration 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Howard P. Rowland

Licensed Embalmer No. 3114

P. O. Address Othello, Mo

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.