

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Homer G. Phillips**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 mos. 4 days**  
(Specify whether \_\_\_\_\_)  
In this community **40 years**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis** **27**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2138 Eugenia**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME **Sinclair Welch** **420**

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Sep.**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **10 2 1896**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**43 7 24** hr. min.

9. Birthplace **unk. 9**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Henry Welch**

13. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Beulah**

15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel May Sheard**

(b) Address **2601 N. Whittier St.**

17. (a) **Burial** (b) Date thereof **6-27-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **Ira Hamilton**

(b) Address **City Health Dept**

19. (a) **JUN 26 1940** (b) **J. F. Braddock**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5-** day **26**  
year **1940** hour **2** minute **05** P. M.

21. I hereby certify that I attended the deceased from **1-22-** 19 **40** to **5-26-** 19 **40**, that I last saw him **im** alive on **5-26-** 19 **40** and that death occurred on the date and hour stated above.

Immediate cause of death **Aortitis, Syphilitic** **About 10**  
Duration Yrs.

Due to **Aneurysm, Aorta**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of autopsy **As above**

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature **H. J. Sisman** (M. D. or other) \_\_\_\_\_

Address **2601 N. Whittier** Date signed **5-31-1940**

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**