

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30387

Registrar's No. 7664

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:
En Route to City Hospital #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community En Route to City Hospital #1 (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 12
 (If outside city or town limits, write "RURAL.")
 (d) Street No. 4640 Delmar Blvd
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11th
 year 1940 hour 5:46 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Myocarditis;
Arterio Sclerosis;

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically

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)
 (e) Means of injury _____

23. Signature [Signature] (M.D. or other) _____

Address [Signature] _____

3. (a) PRINT FULL NAME Lillie Weltin

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Albert S. Weltin 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
About 65 hr. _____ min.

9. Birthplace Boston Mass.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Wolfe

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

14. Maiden name Mary Martin

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

16. (a) Informant's own signature _____

(b) Address Kansas City Mo

17. (a) Burial (b) Date thereof September 13
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) SEPT. 12, 1940 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

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, *Francis J. Duran*

Licensed Embalmer No. *2245*

P. O. Address *St. Louis, 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.