

FILED JUN 19 1945

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1242

1. PLACE OF DEATH: St. Louis

(a) County St. Louis

(b) City or town Koch, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 682 days
(Specify whether life)

In this community life
years, months or days

3. (a) PRINT FULL NAME WELCH, John John

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex m 5. Color or race wh

6. (a) Single, widowed, married, divorced, divorced

6. (b) Name of husband or wife Genevieve Bernhardt

6. (c) Age of husband or wife if alive 25 years (Day) (Year)

7. Birth date of deceased 11 (Month) 25 (Day) 99 (Year)

8. AGE:	Years	Months	Days	If less than one day
46	<u>45</u>	<u>5</u>	<u>29</u>	hr. min.

9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name John Welch

13. Birthplace New Orleans La. (City, town, or county) (State or foreign country)

14. Maiden name Bridget McCarroll

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

16. (a) Informant Koch Hospital Records

(b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (c) Signature of funeral director: A. W. McLaughlin
2301 Lafayette Ave.

19. (a) JUN 1 1945 (Date received local registrar) (b) C. G. McCawley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 1712 Chouteau (If rural, give location)

(e) Citizen of foreign country? / (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24 year 1945 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from 7/2 1943, to 5/24 1945; that I last saw him alive on 5/24 1945; and that death occurred on the date and hour stated above.

Immediate cause of death primary tuberculosis

Due to 136'

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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? _____

(Specify type of place) _____ While at work? _____ (e) Means of injury _____

23. Signature Bernard Friedman (M. D. or other) M.D.
Address Koch Hosp., Koch, Mo. Date signed 5-25-45

Duration 2 years 6 months

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

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

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 *L.R. Cooper*

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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, fact should be so stated above.