S. No. 2
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v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29468

FILED SEP 21 1945

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7961

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips, Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 199
(c) City or town East St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 116 N. 9th. St.
(If rural, give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Robert Welch
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Isabella Welch
6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased July (Month) 5 (Day) 1898 (Year)

8. AGE: Years	Months	Days	If less than one day
47	2	1	hr. min.

9. Birthplace Dyle, Tenn. (City, town, or county) (State or foreign country)
10. Usual occupation Plumbing
11. Industry or business None

MOTHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Isabella Welch
(b) Address 116 N. 9th. St. East St. Louis Ill.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director C. W. Nash
(b) Address 1113 N. 13th St.
19. (a) SEP 11 1945 (Date received local registrar) (b) J. Medel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6 year 1945 hour 8 minute 55 P.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: Subarachnoid hemorrhage
Duration
Due to: Hypertensive cardiovascular disease
Due to: while he was
Due to: Colle fracture
Due to: Colonoscopy
Other conditions (Include pregnancy within 3 months of death): Aug. 31, 1945
Major findings: Of operations: 170
Of autopsy: JK.

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence Aug. 31, 1945
(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 Patrick E. Naylor (M. D. or other) Dep. Cor
Address 1300 Clark Date signed 9-1-45

(Licensed Embalmer's Statement on Reverse Side)

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 C. J. Nash

Licensed Embalmer No. 2432

P. O. Address 111 N. 13th St.

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.