

S. No. 2
M-5-43
v. 5-17-39
I X36671

49077
DEPARTMENT OF COMMERCE
BUREAU OF CONSUL

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35989

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9719**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution **St. Louis City Hospital**
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **ROY WELTON**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **497-03-9741**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, 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 **May 15 1886**
(Month) (Day) (Year)

8. AGE: Years **59** Months **5** Days **24** If less than one day
.....hr.min.

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

10. Usual occupation **Unknown**

11. Industry or business.....

12. Name **UNK. WELTON**

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

14. Maiden name **UNK. UNK.**

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

16. (a) Informant **Mrs. M. Woder**
(b) Address **812 S. 12th St.**

17. (a) **BURIAL** (b) Date thereof **NOV-10-45**
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. MATTHEWS**

18. (a) Signature of funeral director **E. J. Schurer**

(b) Address **3125 Lafayette Ave.**

19. (a) **NOV 10 1945** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **112 S. 4th ST.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **8**
year **1945** hour **1:30** minute **P** M.

21. I hereby certify that I attended the deceased from **October 30**, 19**45**, to **November 8**, 19**45**,
that I last saw him alive on **November 8**, 19**45**,
and that death occurred on the date and hour stated above.

Immediate cause of death **artery sclerosis**
Heart Disease

Due to.....
Due to.....

Other conditions **neoplasm of lung**
(Include pregnancy within 3 months of death)
Type Undetermined

Major findings:
Of operations.....

Of autopsy.....

Duration
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.....
(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 **W. J. Woder** (f. D. or other)
Address **1515 Lafayette Avenue** Date signed **11/8/45**

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

MOTHER FATHER

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 *Jos. B. Kollmer*
Licensed Embalmer No. 4014
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, fact should be so stated above.