

STANDARD CERTIFICATE OF DEATH

State File No. **6965**

FILED FEB 25 1946  
Registration District No. **277**

Primary Registration District No. **3063**

Registrar's No. **427**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hr. 55 min.  
(Specify whether years, months or days)

In this community City Resident

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6-20

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. Ozanam Shelter - 3225 Montanmer  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRED WELCH

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 192-12-1574

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13th  
year 1946 hour One minute 45 AM.

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

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

7. Birth date of deceased August 26 1883  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 12 1946 to February 13 1946  
that I last saw him alive on February 13 1946  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>5</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death  
Head injury resulting from being struck by an auto - accidental death  
[Peperation]

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

Due to 17 Oct 8

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Retired

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

12. Name Unknown

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Manuel M. Kamterman

(b) Address 1436a Laurel, St. Louis

17. (a) Burial (b) Date thereof 2-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

22. If death was due to external causes, fill in the following: 96

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence February 12th, 1946

(c) Where did injury occur? Wellston St., Lo. Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Highway

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Hit by Auto

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 2-20-46 (b) E. M. Gorman MD  
(Date received local registrar) (Registrar's signature)

23. Signature Clara Havel (M. D. or other) \_\_\_\_\_  
Address 601 Broadwood Date signed 2-15-46

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

5916

**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 *Elmo R. Cadwell*

Licensed Embalmer No. *4077*

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, fact should be so stated above.**