

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 37 days.
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Hester Loren Welsh

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

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

6. (b) Name of husband or wife Mae Welsh 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased April 16 1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 8 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Electrical Repairman

11. Industry or business _____

12. Name Unknown Welsh

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

14. Maiden name Martha Welsh

15. Birthplace Unknown Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mae Welsh

(b) Address Cape Girardeau, Missouri

17. (a) Burial (b) Date thereof 1/9/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) JAN 7 1948 (b) J. F. Medical
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. 460 North Pacific Street.,
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1948 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from Dec. 1 1947 to Jan 6 1948
that I last saw him alive on Jan 6 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Come Duration _____

Due to Lumbar vertebrae of lower

Due to 55

Other conditions Multiple myeloma
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy multiple myeloma

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 0

23. Signature J. F. Medical (M. D. or other) _____
Address Barnes Hospital Date signed 1-6-48

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

2
45
38
47070

16
/ 4
/ 1

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 *John S. Denne*

Licensed Embalmer No. *4194*

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.