S. No. 2
M—1/47
5-17-39

96
0
0

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 23 1948
Registration District No. 3149

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 11150
Registrar's No. 660

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 yrs - 7 days (Specify whether
In this community 6 years - 7 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County ~~St. Louis~~ 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3890 McDonald Ave. 9
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME WELZ, William A.
3. (b) If veteran, name war WW-1
3. (c) Social Security No. Unknown
4. Sex Male 0
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lee Welz
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased February (Month) 7 (Day) 1891 (Year)

8. AGE: Years 57 Months 1 Days 1 If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Musician
11. Industry or business
FATHER
12. Name Adolph Welz
13. Birthplace Unavailable (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Kate - Unavailable
15. Birthplace Unavailable (City, town, or county) (State or foreign country) 9
16. (a) Informant Registrar
(b) Address VA Hosp. Jefferson Brks. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/48 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park
18. (a) Signature of funeral director Wacker-Helderle U Co
(b) Address 3634 Gravois St. Louis Co.
19. (a) 3-10-48 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1948 hour 9:20 minute A. M.
21. I hereby certify that I attended the deceased from March 1, 1942, to March 8, 1948;
that I last saw him alive on March 8, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary arteriosclerosis
Heart disease
~~XXXX~~ Contributory cause:
ACUTE GASTRIC DUODENAL DILATION,
~~XXXX~~ CORONARY ARTERIOSCLEROSIS WITH
NARROWING OF THE LAD. PULMONARY EDEMA,
~~XXXXXXXX~~ ATROPHY OF LIVER, DEFORMING
(Include or guarantee within 3 months of death)
RHEUMATUM ARTHRITIS
Major findings:
Of operations
Of autopsy Autopsy performed (see cause of death)

Duration

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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 0
23. Signature [signature] M. D. ~~or other~~
Address Jefferson Barracks, Mo. Date signed 3/8/48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

APR 25 1942

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 Frank J. Ryland Sr.

Licensed Embalmer No. 2675

P. O. Address San Lorenzo

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.