

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14018

State File No. ....

BIRTH NO. .... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3293

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Ellis Grove</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		STREET ADDRESS (If rural, give location) <u>Near Ellis Grove Ill.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ella</u> b. (Middle) <u>Rosella</u> c. (Last) <u>Welch</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 19, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>65</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>Prairie Hill, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Sterling Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Graves</u>	
14. NAME OF HUSBAND OR WIFE <u>Joseph Welch.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, War or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. M. Sutter 4325 Cyprus Rd.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renal insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Polycystic Renal Disease</u> DUE TO (c) <u>Congenital</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hydrothorax, recurrent</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>7571</u>		22. I hereby certify that I attended the deceased from <u>3-4 (9) March 55, to 9 April, 19 55</u> , that I last saw the deceased alive on <u>9 April, 19 55</u> , and that death occurred at <u>6:35 P. m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>J. Demming M.D.</u>		23b. ADDRESS <u>216 So. Kingshighway st.</u>	
23c. DATE SIGNED <u>11 April</u>		24. NAME OF CEMETERY OR CREMATORY <u>Local</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. LOCATION (City, town, or county) (State) <u>Salisbury, Mo.</u>	
24c. DATE REC'D BY LOCAL REG. <u>APR 12 1955</u>		24d. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

APR 28 1967

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John J. Haine*  
Licensed Embalmer No. *408*  
P. O. Address *Haine*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.