

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4032**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Honors Phillip Hosp		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) 4327 Kennelby	

3. NAME OF DECEASED a. (First) Michael		b. (Middle)		c. (Last) Welch		4. DATE OF DEATH (Month) (Day) (Year) May 5 1955	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 16 Aug 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Territory, Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.	

13a. FATHER'S NAME Robert Welch		13b. MOTHER'S MAIDEN NAME Katherine Allen		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Welch 4327 Kennelby	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lead poisoning.		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO suffered when deceased			
		DUE TO ate plaster from wall in			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. same, May 5, 1955, exact			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none unknown.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 5 55 ? m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E8860	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2351** _____, from the causes and on the date stated above. **14**

23a. SIGNATURE (Print name or title) Gatriek C. Taylor Coroner		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 5.6.55.	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9 May 55		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
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DATE REC'D BY LOCAL REG. MAY 6 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Reliable Funeral Sps 1221 No Taylor	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Paul V. Freeman*

Licensed Embalmer No. *4686*
P. O. Address *4729 Hammon*

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.