

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020269  
STATE FILE NUMBER

318

1003

Registrar's No. 5634

FILED JUN 11 1958

Registration District No.

Primary Registration District No.

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L-57

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY                                             |                                                                           |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                      | c. CITY OR TOWN St. Louis                                                                                                                                   |                                                                           |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                      | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                      |                                                                           |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 1650 So. 39th St.                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                      | d. STREET ADDRESS (If outside, give location)<br>1650 So. 39th St.                                                                                          |                                                                           |
| Length of stay in 1b                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                      | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                     |                                                                           |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>RUFUS A. WELKER                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      |                                                                                                                                                             | 4. DATE OF DEATH<br>Month Day Year<br>May 29 1958                         |
| 5. SEX<br>Male <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. COLOR OR RACE<br>White                                                                                            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Nov. 22, 1886                                         |
| 9. AGE (In years last birthday)<br>71                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Engineer-Frisco R. Co. | 11. BIRTHPLACE (City and state or country)<br>Missouri 0                                                                                                    | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                    |
| 13a. FATHER'S NAME<br>Allen Welker                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13b. MOTHER'S MAIDEN NAME<br>Martha Yount                                                                            | 14. NAME OF HUSBAND OR WIFE<br>Ava M. Welker                                                                                                                |                                                                           |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, or (X) unknown) (If yes, give what of service)<br>None                                                                                                                                                                                                                                                                                                                                                            | 16. SOCIAL SECURITY NO.<br>495-16-3327                                                                               | 17. INFORMANT<br>Address<br>Ava M. Welker 1650 S. 39th St.                                                                                                  |                                                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio-sclerosis</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>332x</u> |                                                                                                                      |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>2 yrs.</u>       |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                      |                                                                                                                                                             |                                                                           |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                         |                                                                                                                                                             |                                                                           |
| 20c. TIME OF INJURY<br>Hour .Month, Day, Year<br>a.m.<br>p.m.                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                      |                                                                                                                                                             |                                                                           |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                       | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             | 20f. CITY, TOWN, OR LOCATION                                                                                                                                | COUNTY STATE                                                              |
| 21. I attended the deceased from <u>Jan. 1956</u> to <u>May 28, 1958</u> and last saw her alive on <u>May 28, 1958</u><br>Death occurred at <u>5:30 A.</u> on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                           |                                                                                                                      |                                                                                                                                                             |                                                                           |
| 22a. SIGNATURE<br><u>E.R. Sheridan, M.D.</u> (Degree or title)                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                      | 22b. ADDRESS<br><u>#16 Hampton Village Plaza</u>                                                                                                            | 22c. DATE SIGNED<br><u>5-29-58</u>                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>                                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><u>May 31, 1958</u>                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park Cem.</u>                                                                                             | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Co. Mo.</u> |
| 24. FUNERAL DIRECTOR<br><u>Kriegshauser</u> ADDRESS<br><u>4228 S. Kingshighway</u>                                                                                                                                                                                                                                                                                                                                                                                      | 25. DATE RECD. BY LOCAL REG.<br><u>MAY 29 '58</u>                                                                    | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith MD</u><br><u>mks</u>                                                                                             |                                                                           |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *William B. White* .....

Licensed Embalmer No. *1291* .....

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