Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002588 STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY St. Charles	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Charles — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Charles — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph — Length of stay in 1b 1 Month	d. STREET ADDRESS (If outside, give location) 209 So, Main St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Arthur, Middle W., Last Welch

4. DATE OF DEATH: Month Jan. Day 17, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb.24,1886

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months 10, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Worker

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (City and state or country): Davis, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: unknown

13b. MOTHER'S MAIDEN NAME: unknown

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): NO

16. SOCIAL SECURITY NO.: 489-14-5154

17. INFORMANT: Otto Boekemeier, Address St. Charles, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 6000

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 December 1957 to January 17 1959 and last saw her/him alive on Jan. 17 1959. Death occurred at 7:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Don L. Randall, M.D.

22b. ADDRESS: 207 N. 5th St. Charles, Mo.

22c. DATE SIGNED: Jan. 19, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan.20,1959

23c. NAME OF CEMETERY OR CREMATORY: St. Peter Cemetery

23d. LOCATION (City, town, or county) (State): St. Charles, Mo.

24. FUNERAL DIRECTOR ADDRESS: H.C.Dallmeyer & Sons, St.Charles Mo.

25. DATE RECD. BY LOCAL REG.: Jan. 19-59

26. REGISTRAR'S SIGNATURE: Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Gene A Matthews

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, Mo.

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.