

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011498

STATE FILE NUMBER

2648

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Decay, coroner, etc. must use only standard nomenclature in item 18. No symptoms with be related. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hosp., Inc.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>3537 N. 23rd St.</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Welschan</b>			4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1899</b>
9. AGE (In years last birthday) <b>60</b>		10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Benjamin Welschan</b>	
13b. MOTHER'S MAIDEN NAME <b>Lena Hahn</b>		14. NAME OF HUSBAND OR WIFE <b>Rose Welschan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489-05-9744</b>	17. INFORMANT <b>Rose Welschan</b> Address <b>3537 N. 23rd St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 Weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>Coronary Artery Disease 420.</b>			<b>Several Yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 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 Hour _____ Month, Day, Year _____ a.m. _____ 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 Death occurred at <b>March 4, 1959</b> to <b>March 15, 1959</b> and last saw <del>him</del> <sup>her</sup> alive on <b>March 14, 1959</b>		Death occurred at <b>4:45 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>R. Harrison M.D.</i> (Degree or title)		22b. ADDRESS <b>1755 S. Grand Blvd.</b>	22c. DATE SIGNED <b>3-16-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>3-18-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Leidner Funeral Home</b> ADDRESS <b>St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 16 '59</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

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 *Ed Mayfield* .....

Licensed Embalmer No. *3077* .....

P. O. Address *St. Louis, 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.