

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-013374

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2504** STATE FILE NUMBER

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MISSOURI</b>         |  | Length of stay in 1b   | c. CITY OR TOWN <b>University City</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give department)<br>HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>712 Swathmore</b><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |  |                                     |  |  |
|---|----------------------------------|---|--|-------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CLAUDE</b> Middle <b>L.</b> Last <b>WELCH</b> |                                  |   | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>1</b> Year <b>1960</b> |                                     |  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 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><b>1-7-1909</b>                                  | 9. AGE (last birthday)<br><b>51</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |

|   |  |  |   |  |  |   |  |
|---|--|--|---|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Products Control Mgr.</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ralston Purina</b> |   | 11. BIRTHPLACE (City and state or country)<br><b>Indiana</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>            |  |
| 13a. FATHER'S NAME<br><b>Floyd E. Welch</b>   |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Iva Lough</b> |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Mary Elenor Welch</b> |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>494-05-5021</b> |  | 17. INFORMANT<br><b>Mrs. Calude Welch 712 Swathmore Ia.</b> |  |
|---|--|---|--|---|--|

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>HEMORRHAGIC NECROSIS OF ADRENAL GLANDS</b>  |  |  | <b>FEW HOURS</b>                 |
| DUE TO (b) <b>SUSPECTED SEPTICEMIA, ETIOLOGY UNKNOWN</b>   |  |  | <b>12 HOURS</b>                  |
| DUE TO (c) <b>053.4</b>  |  |  |                                  |

|  |  |  |  |
|--|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>HEREDITARY SPHEROCYTOSIS</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|--|--|--|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.<br>Month, Day, Year _____                    |  | 20d. INJURY OCCURRED WHILE AT WORK <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 **AUG. 26, 1953** to **MARCH 1, 1960** and last saw her/him alive on **MARCH 1, 1960**  
Death occurred at **9:40 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |  |  |                                   |  |
|--|--|--|--|-----------------------------------|--|
| 22a. SIGNATURE<br><i>C. P. Venillia, M.D.</i> (Degree or title) <b>M. D.</b> |  | 22b. ADDRESS<br><b>BARNES HOSPITAL</b> |  | 22c. DATE SIGNED<br><b>3/2/60</b> |  |
|--|--|--|--|-----------------------------------|--|

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b> |  | 23b. DATE<br><b>3-4-1960</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK GROVE MAUSOLEUM</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co. Mo.</b> |  |
|---|--|------------------------------|--|--|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br><b>C.R. Lupton and Sons 7233 Delmar Blv'd.</b> |  | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 3 1960</b> |  | 26. REGISTRAR'S SIGNATURE<br><i>Roald Smith, M.D.</i> |  |
|--|--|---|--|---|--|

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 5 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arnold W. Schoen

Licensed Embalmer No. 3864  
P. O. Address St. Louis

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.