

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017460

FILED VS. MAY 13 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **4421**

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, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 5 DAYS		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6331 MARDEL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First WILLIAM Middle T. Last WELD				4. DATE OF DEATH Month APRIL Day 23 Year 1960									
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/1/1896		9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSULTANT				10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		11. BIRTHPLACE (City and state or country) SLAYTON, MINNESOTA		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME CHARLES WELD				13b. MOTHER'S MAIDEN NAME EDORA ALLEN				14. NAME OF HUSBAND OR WIFE MARY R. WELD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR ONE				16. SOCIAL SECURITY NO. 490-12-1537		17. INFORMANT Address MRS. MARY R. WELD, 6331 MARDEL, ST. LOUIS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE										INTERVAL BETWEEN ONSET AND DEATH 5 YRS.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia, Cholelithiasis, Emphysema, Cerebral edema								PART III. If deceased was female was there a pregnancy in last 90 days. <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 Hour - Month, Day, Year a.m. p.m.		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 7-14-57 to 4-23-60 and last saw ^{her} him alive on 4-23-60 Death occurred at 9:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) William T. Fitzgerald M.D.				22b. ADDRESS 3915 WATSON Rd				22c. DATE SIGNED 4-25-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 4/26/1960		23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY		23d. LOCATION (City, town, or county) (State) 3211 SUBLETT AVE. ST. LOUIS, MO.							
24. FUNERAL DIRECTOR ADDRESS HOPFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET, ST. LOUIS (9) MO.				25. DATE RECD. BY LOCAL REG. APR 25 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D. <i>WJB</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Levin C. Hoffman

Licensed Embalmer No. 3871

P. O. Address 7814 S. B...

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.