

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 5 1960

-60-044788

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RIVER AUX USAE MO</u>	Length of stay in 1b <u>5 YRS</u>	c. CITY OR TOWN <u>RIVER AUX USAE MO</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle _____ Last <u>WELCH</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/02</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>DALLAS TEX</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>JOHN WELCH</u>		13b. MOTHER'S MAIDEN NAME <u>DORA BELL</u>		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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>493-07-7562</u>		17. INFORMANT <u>Family Record</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Circulatory Collapse</u>		<u>2h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Rel. Congestive Heart Failure</u>	<u>6 months</u>
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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 _____ a.m. _____ p.m.	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 May, 1960 to Nov. 26, 1960 and last saw him alive on Nov. 26, 1960
 Death occurred at Nov. 28, 1960 6 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ronald E. Harris MD.</u> (Degree or title)	22b. ADDRESS <u>St. Genevieve Mo</u>	22c. DATE SIGNED <u>12-3-60</u>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/3/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CREST LAWN</u>	23d. LOCATION (City, town, or county) (State) <u>STE. GENEVIEVE MO.</u>
--	-----------------------------	---	--

25. DATE RECD. BY LOCAL REG. <u>12-3-1960</u>	26. REGISTRAR'S SIGNATURE <u>John D. [Signature]</u>
--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 2 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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Adrian J. Eller

Licensed Embalmer No. 4740

P. O. Address Sta. Gene.

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.