

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318 Primary Registration District No. 1003 Registrar's No. 4274 -61-015743 STATE FILE NUMBER

AMENDED FILED Registration District No. 1061 MAY 10 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 day	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 Little Flower Nursing Home		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6955 Winona Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Magdalen Middle M. Last Welling			4. DATE OF DEATH Month May Day 3 Year 1961		
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1874	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Nicholas Schaefer		13b. MOTHER'S MAIDEN NAME Mary Mace		14. NAME OF HUSBAND OR WIFE John H. Welling	
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. None	17. INFORMANT Address Josephine Barclay 3019 Ivanhoe Ave.		
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) CEREBRO-VASCULAR - Thrombosis					6 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HTATAL HERNIA & Hemorrhage					10 YRS
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS					15 YRS
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. 332x <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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 MARCH 15, 1961 to MAY 3, 1961 and last saw her ^{her} _{been} alive on MAY 2, 1961 Death occurred at 12:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Johna Carner, M.D. (Degree or title)			22b. ADDRESS 4401 Hampton, St. Louis 9, Mo. 5-4-61		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/6/1961	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Hofmeister Colonial Mortuary ADDRESS 6464 Chipewa St. St. Louis, Mo.			25. DATE RECD. BY LOCAL REG. MAY 5 1961	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Dice C. Branson*

Licensed Embalmer No. 4764
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.