

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050078

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 13109 STATE FILE NUMBER

FILED JAN 9 1964

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before institution) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Edgewater Nursing Home		d. STREET ADDRESS (If outside, give location) 4844 S Broadway	Inside Limits Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Otto Welz			4. DATE OF DEATH Month Day Year December 30 1963
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 74
11a. FATHER'S NAME Adolph Welz		11b. MOTHER'S MAIDEN NAME not known	11c. BIRTHPLACE (City and state or country) St. Louis, Mo.
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO.	12c. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Adolph Welz		13b. MOTHER'S MAIDEN NAME not known	13c. NAME OF HUSBAND OR WIFE Ida
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14a. SOCIAL SECURITY NO.	14b. INFORMANT Ida Welz 4844 S Broadway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Coronary Arteriosclerosis</i>			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 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.) <i>491x</i>	
20c. TIME OF INJURY Hour 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 <i>July 22, 1963</i> to <i>Dec 30, 1963</i> and last saw him alive on <i>Dec 30, 1963</i> Death occurred at <i>10:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert D. Sanders, MD</i>		22b. ADDRESS <i>5500 S Broadway</i>	22c. DATE SIGNED <i>12-31-63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) mausoleum	23b. DATE 1/3/1964	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum	23d. LOCATION (City, town or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR John L Ziegenhein & Sons 7027 Gravois		25. DATE RECD. BY LOCAL REG. JAN 3 1964	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

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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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.