FILED OCT 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33101

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1674

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Koch Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 mo 5 da (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St Louis
(If outside city or town limit write "RURAL")
(d) Street No. 1302 N Market
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Welch
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Francis Welch
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 12-2-1906 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
33	9	1	hr. min.

9. Birthplace Washington (City, town, or county) D C (State or foreign country)
10. Usual occupation Pro. Baseball player
11. Industry or business
FATHER 12. Name Geo Welch
13. Birthplace Wash (City, town, or county) D C (State or foreign country)
MOTHER 14. Maiden name Jennie Sullivan
15. Birthplace (City, town, or county) W Virginia (State or foreign country)
16. (a) Informant Mrs Frances Welch
(b) Address 1300 N. Market St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director [illegible]
(b) Address 2223 St Louis Ave
19. (a) SEP - 3 1940 (Date received local registrar) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3 year 40 hour 9 minute 20 A M.
21. I hereby certify that I attended the deceased from 11-18-39, 19 , to Aug 3, 1940; that I last saw him alive on 9/3, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculous meningitis	3 wk
Due to Pulmonary Tuberculosis	2 yr
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature William Stuber (M. D. or other) MD
Address Koch Mo Date signed 9/3/40

(Licensed Embalmer's Statement on Reverse Side)