

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

08722

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Anne Arundel
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 266 King Geo St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME B. Allein Welch 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Susan Welch

7. Birth date of deceased (mo., day, yr.) Mar 25th 1862 6. (c) If alive, give age _____ years

8. AGE: Years 83 Months 5 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace A A C Md.
 (Town, county and state)

10. Usual occupation Pres of Annapolis

11. Industry or business Savings Bank

12. Name Benjamin A. Welch

13. Birthplace Annapolis Md.

14. Maiden name Lucinda Wendell

15. Birthplace A A C Md.

16. Informant Miss Gertrude Welch

Address MT Zion A A C Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Sept 12th 1945
 (month) (day) (year)

Cemetery or crematory Christ Church

Location Cavensville G A C Md.

18. Funeral director John M Taylor

Address Annapolis Md.

19. Sept. 11 19 45
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 19 45 at 10⁰⁵ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 19 45 to Sept 10 19 45 and that I last saw him alive on September 10 19 45

Immediate cause of death Chronic myocarditis
Valvular heart disease

DURATION
<u>Not known</u>

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nalton H. Hays MD
 M. D. or other _____

Address Annapolis Md. Date signed 9-11-45

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