

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33045

1. PLACE OF DEATH

County Cole Registration District No. 213 File No.
 Township Primary Registration District No. 3014 Registered No. 303
 City Jefferson (No.) St. Ward)

2. FULL NAME

(a) Residence. No. 816 Mulberry St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 20 - 1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	1	2	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jefferson City
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Kelch

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Elaton
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Katherine Martin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sedalia
 (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. Kelch
 (Address) St. Peters Lem.

15. FILED Dec. 1 / 27 19 27
S. G. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis cere spinal
Pneumococcus
 (duration) yrs. mos. 5 da.
 CONTRIBUTORY Pneumonia
 (SECONDARY) (duration) yrs. mos. 15 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

20. WAS THERE AN AUTOPSY?

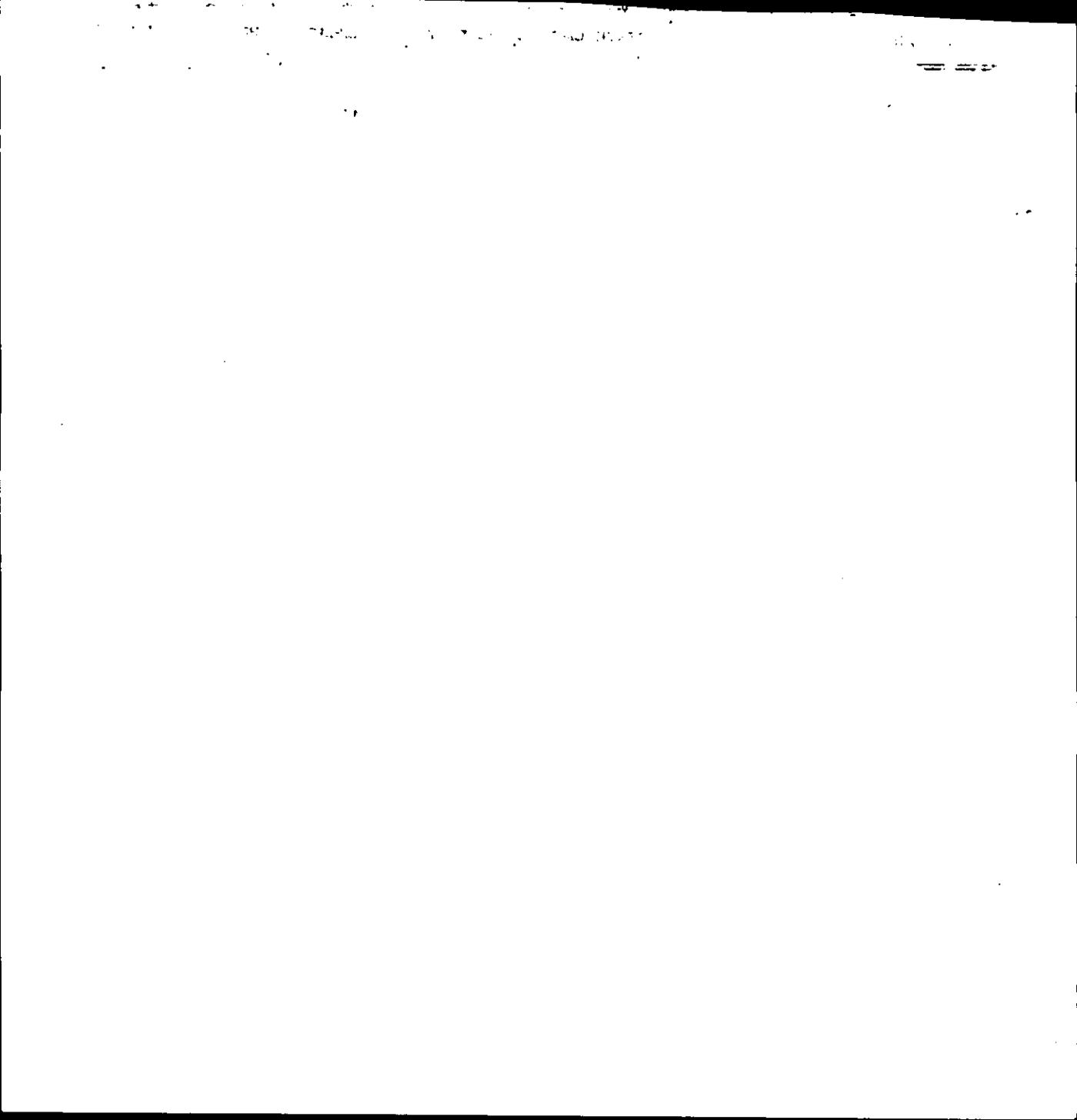
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. W. Bedford M. D.
 , 19 (Address) St. Peters Lem. Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Peters Lem. DATE OF BURIAL 11-28-1927

20. UNDERTAKER C. P. Heinriche ADDRESS St. Peters Lem. Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Cole Registration District No. 2, 3 File No. _____
 Township _____ Primary Registration District No. 3014 Registered No. 303
 City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME

Loretta Elene Welch
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

PARENTS

14. INFORMANT _____
 (Address)

15. FILED 12-1 1927 J. W. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 27 19 27

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis Cere spinal
Pneumococic
Broncho (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Pneumonia & Influenza
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

C. P. Heinrichs

SUPPLEMENTARY

S-73046