

REC'D APR 25 1939

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

11489

Do not use this space.

1. PLACE OF DEATH *Macon* 2
(a) County *Macon* Registration District No. *533*
(b) Township *Macon* Primary Registration District No. *3027* Registered No. *36*
(c) City *Macon* (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
4.22

2. PRINT FULL NAME *Rebecca Ann Welch*
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar. 15" 1851*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, 0 hr. or 0 min.
88 0 6
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. *Retired Nurse*
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation. *Wife*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

FATHER 13. NAME *William Voiles*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

MOTHER 15. MAIDEN NAME *Elizabeth Willis*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

17. INFORMANT (ADDRESS) *Otis Welch*
Macon, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE *March 23, Oakwood cem.* DATE *1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Stephens Gooding*
Macon, Mo.

20. FILED *4/6* 1939 *Seola Hunter* Local Registrar. *477*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar. 21" 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 10*, 1939, to *Mar 20*, 1939

I last saw her... alive on *Mar 29, 1939*. Death is said to have occurred on the date stated above, at *5:20 am*.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Other contributory causes of importance:

asthma

Name of operation *None* Date of _____

What test confirmed diagnosis? *Chol* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *O. West*, M. D.

(Address) *New Orleans, Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2014-1-33 I X14028

RECEIVED

District Health Officer No. 10

District File Number 10-39-634

Date Filed APR 20 1939

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,

O. L. Stephens

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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 this body is not embalmed, above space should be left blank.