

JAN 12 1940

Registration District No. 266Primary Registration District No. 4164Registrar's No. 96

1. PLACE OF DEATH:

(a) County Dent 2
 (b) City or town Salem
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XXXXX
 (Specify whether
 In this community all his life
 years, months or days)

3. (a) PRINT FULL NAME G. Noel Welch3. (b) If veteran, name war XXX 3. (c) Social Security No. XX4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years7. Birth date of deceased June 6 1909
(Month) (Day) (Year)8. AGE: Years 30 Months 6 Days 11 If less than one day
hr. _____ min. _____9. Birthplace Shannon Co Mo
(City, town, or county) (State or foreign country)10. Usual occupation laborer11. Industry or business XXX12. Name Albert S Welch13. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)14. Maiden name Ella Wainwright
15. Birthplace Mo
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Albert Welch(b) Address Salem Mo17. (a) burial (b) Date thereof 12/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Way Hope Cem18. (a) Signature of funeral director Carl K. Spencer(b) Address Salem Mo19. (a) Dec 18 1939 (b) F. E. Butler MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Dent
 (c) City or town rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. XXX
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12/17 day 17
year 39 hour 11 minute 15 A. M.21. I hereby certify that I attended the deceased from Nov 1 39
Dec 17 1939, to Dec 17 1939
that I last saw him alive on Dec 15 1939
and that death occurred on the date and hour stated above.Immediate cause of death Pneumonia
BronchialDue to Influenza Duration 3 Days
B 1939

Due to _____

Other conditions ✓
(Include pregnancy within 3 months of death) 11/2Major findings:
Of operations ✓Of autopsy ✓

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

While at work? ✓ (Specify type of place) (e) Means of injury ✓23. Signature F. E. Butler MD (M. D. or other) !Address Salem Mo Date signed 12-19-39

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

43242
Do not use this space.

1. PLACE OF DEATH *Deer*
 (a) County *Deer* Registration District No. *266*
 (b) Township *Salem* Primary Registration District No. *4164* Registered No. *96*
 (c) City *Salem* (d) Street No. _____ St.
 (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.

2. PRINT FULL NAME *C. Noel Welch*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *S*

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.
30 6 11

OCCUPATION
 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. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED *Nov 18 1939 F.E. Butley M.D. Registrar*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/17 1939*

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
 I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
 _____ Date of onset _____
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____
 (Signed) *H. G. Dillon*, M. D.
 (Address) *Salem Mo*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED. EXACT STATEMENT OF OCCASION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PLACE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

