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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 31000

Registrar's No. 3563

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3825 Olive Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community One year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 3825 Olive Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME PETER R. WELCH

3. (b) If veteran, name war None

3. (c) Social Security No. 492-18-9216.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Annie Welch (Dead)

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased September (Month) 3, (Day) 1887. (Year)

8. AGE: Years 53 Months -- Days 5 If less than one day ____ hr. ____ min.

9. Birthplace Wichita, Kansas (City, town, or county) ____ (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Retail Dairy

FATHER
12. Name Thomas Welch
13. Birthplace West Virginia (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name Sarah McCullum
15. Birthplace Illinois (City, town, or county) ____ (State or foreign country)

16. (a) Informant Mrs. Sarah Welch
(b) Address 2208-8th Ave, Greely, Colo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/40. (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem.

18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.

19. (a) Sept. 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ day 9-8-40
year ____ hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from 1:00 P.M. ____, 19__, to ____, 19__;
that I last saw him alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death ____ Duration

Due to Gunshot wound of chest.

Due to ____

Other conditions 167
(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN 167
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) Suicide
(b) Date of occurrence 9-8-40
(c) Where did injury occur? K. C. (City or town) Mo (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 5

23. Signature [signature] (M. D. or other)
Address K. C. Mo. Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

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, or by.....

....., Registered Apprentice No. 267,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2999

P. O. Address.....

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.