

Rev. 5-17-39
I X1951

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35016
Registrar's No. 38

Registration District No. 124 Primary Registration District No. 5783

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural
(c) Name of hospital or institution: White-water Inn
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 2
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME GEORGE WELKER
8. (b) If veteran, name war _____ 8. (c) Social Security No. None
4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hannay Welker 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Not known about 72
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
About 72

9. Birthplace Cape Girardeau Co. Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

11. Industry or business _____
MOTHER FATHER { 12. Name Benjamin Welker
13. Birthplace Not known
(City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles C. ...
(b) Address Jackson Mo
17. (a) Buried (b) Date thereof Oct 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Old Salem
18. (a) Signature of funeral director M. ...
(b) Address Jackson Mo
19. (a) 10-19-40 (b) D. G. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cape Girardeau
(c) City or town Millersville
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 10 #2
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 18
year 1940 hour 7 minute 30 P. M.
21. I hereby certify that I attended the deceased from 10 1940 to Oct 18 1940
that I last saw him alive on Oct 18 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy cerebral Duration 2 days
Due to arterio sclerosis 10 yrs
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____
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? 10-19-40
(Specify type of place) (e) Means of injury _____
23. Signature D. G. ... (M. D. or other) _____
Address Jackson Mo Date signed 10-19-40

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.....
working under my personal supervision.

Signed..... *BA Meyer*

Licensed Embalmer No..... *3051*

P. O. Address..... *Jackson 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.