

DEC 16 1940

Registration District No. 477

Primary Registration District No. 200

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Ewing (Rural)
(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 2
In this community 24 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Catherine Welsh

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John Welsh 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 10 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23
year 1940 hour 7 minute 25 A. M.
21. I hereby certify that I attended the deceased from Nov 7, 1940, to Nov 12, 1940, that I last saw her alive on Nov 12th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Duration _____

8. AGE: Years 80 Months 7 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Monroe Co, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Peter J. Kauer
13. Birthplace Germany 6
(City, town, or county) (State or foreign country)
14. Maiden name Berta Wild
15. Birthplace Germany 6
(City, town, or county) (State or foreign country)

16. (a) Informant Cecilia Stokely
(b) Address Jennings Mo.

17. (a) Burial (b) Date thereof Nov 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ewing Cemetery

18. (a) Signature of funeral director Thomas Ball
(b) Address Ewing, Mo.

19. (a) Nov 24 1940 (b) Sp. W. Jennings M.
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations none
Of autopsy none
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) none
(b) Date of occurrence none
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or public place? none

While at work? none (Specify type of place) (e) Means of injury none

23. Signature Sp. W. Jennings (M. D. or other)
Address Jennings Mo Date signed 11/23/40

1328

21-8-28
21-8-28
22-11-28

RECEIVED

District Health Officer No. 10

District File Number 12-40-2298

Date Filed DEC 13 1940

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 Thomas Ball

Licensed Embalmer No. 1744

P. O. Address Evans, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39102

Registration District No. 477

Primary Registration District No. 200

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
 (b) City or town Lewistown Twp
 (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 _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Catherine Welsch

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 80 Months 8 Days 18 If less than one day _____ hr _____ min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 Arteriosclerosis, following chronic nephritis of long standing
 Due to _____
 Due to _____

Other conditions: (Include pregnancy within 3 months of death) 12/1

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? _____

While at work? _____ (Specify type of place)
 (a) Means of injury _____

23. Signature James W. Lohr, M.D. (M. D. or other) _____
 Address Lewistown, Mo Date signed 1-20-41

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

SUPPLEMENTARY

S-39102 1940