

5-17-39
I X23159

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. 149

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
7
3
1

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston

(c) Name of hospital or institution: West Marshall Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)

In this community 8 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.

City or town Charleston, Mo.
(If outside city or town limits, write "RURAL")

(d) Street West Market Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Zella Welshans

3. (b) If veteran, name war X X X

3. (c) Social Security No. X X X

4. Sex Female 5. Color or race White

6. (a) Single, married, divorced Married

6. (b) Name of husband or wife Fred Welshans

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased March 28 1888
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 21 If less than one day
hr. min.

9. Birthplace Madison Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired House wife

11. Industry or business At home

MOTHER FATHER { 12. Name Not known

13. Birthplace Not known Not known
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Nowlan

(b) Address Charleston, Missouri

17. (a) Burial (b) Date thereof 11-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Lair-Nunnelee Service

(b) Address Charleston, Missouri

19. (a) 11-22-40 (b) F. D. Demm
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1940 hour 8 minute 45 P M.

21. I hereby certify that I attended the deceased from Nov 13
1940, to Nov 19, 1940;
that I last saw her alive on Nov 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure.

Due to Lung abscess 3 da.

Due to Pneumonia 4 days

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

23. Signature Paul S. Baum (M. D. or other) 1

Address Charleston Mo. Date signed 11/27/40

11412

RECEIVED

District Health Officer No. 2

District File Number 1240-1755

Date Filed 12/4/40

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39240

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 561

Primary Registration District No. 3030

Registrar's No. 149

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston
(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 Zella Welsham

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 m

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 52 Months 7 Days 21 If less than one day _____ h. _____ 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 Mo. (b) County Miss
(c) City or town Charleston (If outside city or town limits write "RURAL")
(d) Street No. West Market St (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 29
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 1940 to _____, 1940;
that I last saw him _____ alive on _____, 1940;
and that death occurred on the date and hour stated above.
Immediate cause of death Heart failure Duration _____

Due to Lung abscess

Due to Pneumonia
Tuberculosis

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?

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

23. Signature Paul B. Bam (M. D. or other) MD
Address Charleston Date signed 11/30/40

SUPPLEMENTARY

S-39240 1940