

State File No. _____

Registration District No. 460

Primary Registration District No. 4274

Registrar's No. 60

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

1. PLACE OF DEATH:
 (a) County Lafayette
 (b) City or town Higginsville, Mo.
 (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 2

3. (a) PRINT FULL NAME Margaret Ellen Welborn
 8. (b) If veteran, name-war _____ (c) Social Security No. _____
 4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May-11-1852
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>6</u>	<u>23</u>	hr. _____ min.

9. Birthplace Lafayette County, Aullville Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation House keeper

11. Industry or business _____

MOTHER FATHER
 { 12. Name David M. Welborn
 { 13. Birthplace North Carolina
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Catherine Bodenamer
 { 15. Birthplace North Carolina
 (City, town, or county) (State or foreign country)

16. (a) Informant Jessie C Schoppenhorst
 (b) Address Higginsville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-1940
 (Month) (Day) (Year)
 (c) Place: burial or cremation Zion Hill Cemetery-

18. (a) Signature of funeral director Walter M. Klein
 (b) Address Higginsville, Mo.

19. (a) Dec. 14, 1940 (Date received local registrar) (b) T. J. Webb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette
 (c) City or town Higginsville Mo.
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 4th -1940
 year _____ hour 3:50 minute _____ a.m.

21. I hereby certify that I attended the deceased from Mar 3-4
 _____, 19 _____ to Dec 4, 1940
 that I last saw her alive on Dec 3
 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of
left leg below knee Duration _____
arterio sclerosis cerebral

Due to Paralysis of left side
arterio sclerosis cerebral

Due to High Blood Pressure

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 Walter M. Klein (M. D. or other) _____
 Address Higginsville Date signed 12/6/40

8242

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-10-47

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 Roy F. Wiegman
Licensed Embalmer No. 2883
P. O. Address Wigginsville

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

State File No. 43007
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 460

Primary Registration District No. 4274

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

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Wassouri
(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 Margaret Ellen Welborn

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 S

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 88 Months 6 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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.

20. DATE OF DEATH Month Dec day 4 year 1946 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 Gangrene of left leg below knee

Due to Paralysis of left side
arteriosclerotic cerebral
high blood pressure

Other conditions Central Hemorrhage
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy J. J. W.

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) (c) Means of injury _____

23. Signature W. B. Brackley M.D. (M. D. or other) _____
Address Wassouri Mo Date signed 2/19/47

SUPPLEMENTAL COPY

S-43007