

7. S. No. 2
M-4-12-40
rev. 5-17-39
I X23189

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. H. S. Silsby
7010

State File No. _____

Registrar's No. 109

FILED MAR 11 1943
Registration District No. _____

Primary Registration District No. 5440

39
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: Route # 7
(d) Length of stay: In hospital or institution 1
In this community 1 years, months or days

3. (a) PRINT FULL NAME Mary Jane Welch
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Female 5. Color or race White
6. (a) Single, widowed, divorced, widowed
6. (b) Name of husband or wife Chas. C. Welch
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased April 30 1848

8. AGE: Years 1 92 Months 9 Days 6 If less than one day hr. min.

9. Birthplace New Philadelphia Ohio

10. Usual occupation _____

11. Industry or business None

MOTHER FATHER
12. Name Andrew Grim
13. Birthplace Unknown Ohio
14. Maiden name Margaret Hogue
15. Birthplace Unknown Ohio

16. (a) Informant Mary Welch
(b) Address Route # 7 Springfield, Mo.

17. (a) Burial (b) Date thereof Feb. 8 1941
(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 2-8-41 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. Route # 7 Box 185
(e) If foreign born, how long in U. S. A. 0 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 6
year 1941 hour 3 minute 2 M.

21. I hereby certify that I attended the deceased from July 7, 1939, to Feb. 4, 1941,
that I last saw her alive on Feb. 4, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Due to Myocardial degeneration
Due to Chronic myocarditis
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____

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? _____
(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 _____
Signature H. S. Silsby (M. D. or other)
Address 923 N. Main Date signed 2/16/41

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. 3177 working under my personal supervision.

Signed J. P. Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield 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, fact should be so stated above.

+