

No. 2
-13-40
17-39
X23159

State File No. _____

FILED AUG 15 1941
Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 538

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
955 W. Lynn
(If not in hospital or institution, give street number or location)

(d) Length of stay: In hospital or institution _____
In this community 21 years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene ⁰³⁹

(c) City or town Springfield ²
(If outside city or town limits, write "RURAL") ⁶

(d) Street No. 955 W. Lynn
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years. ⁰

3. (a) PRINT FULL NAME LINUS E. WELSH

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mina Welsh 6. (c) Age of husband or wife if deceased deceased

7. Birth date of deceased April 23 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>2</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Washington Co. Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business and Bernan Factory withman

12. Name James T. Welsh

13. Birthplace Washington Co. Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Miss Mary E. Welsh

(b) Address 955 W. Lynn Springfield, Mo.

17. (a) Burial (b) Date thereof July 5, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director A. C. Higgins

(b) Address Springfield, Mo.

19. (a) 7-3-1941 (b) W. E. Handley, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2nd
year 1941 hour 11:05 minute _____ P. M.

21. I hereby certify that I attended the deceased from 6-17- 1941 to 7/2/ 1941
that I last saw him alive on 7-2- 1941
and that death occurred on the date and hour stated above

Immediate cause of death Coronary Occlusion
Coronary heart block

Due to 94A

Other conditions Serility
(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 O. E. Feller (M. D. or other) D
Address Springfield, Mo. Date signed 7/3/41

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

MOTHER FATHER

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.....

Self

....., Registered Apprentice No.

working under my personal supervision.

Signed

R. H. Weine

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.