No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40847

Registration District No. 79 Primary Registration District No. 1002 Registrar's No. 4524

48
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3231 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 14 Years 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048
(a) State Missouri (b) County Jackson 2
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 Colorado
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Emma Welch

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

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Ben Welch 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased April (Month) 25 (Day) 1864 (Year)

8. AGE: Years 75 Months 7 Days 10 If less than one day hr. min.

9. Birthplace c (City, town, or county) Kansas 1 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Harris
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Stone
(b) Address 2600 Spruce St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/41 (Month) (Day) (Year)
(c) Place: burial or cremation Fort Scott Kans.

18. (a) Signature of funeral director Rose & Henderson
(b) Address 15th. Jackson K.C. Mo.

19. (a) 12/6/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-4-41 day
year hour minute 7 P M.

21. I hereby certify that I attended the deceased from
Deputy Com
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 Duration
Cerebral Encephalomalacia
Due to
Cerebral Arteriosclerosis
Due to
Other conditions 83c
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Russell W. Fox (M. D. or other) 3
Address C C Van Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address K. C. Mo

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

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