7. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 22 1944

Registration District No. ____ Primary Registration District No. 1002

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40414

Registrar's No. 5015

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: 3918 Wyandotte
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether)
In this community: 80 yr.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 3918 Wyandotte
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME: AMANDA WELCH
3. (b) If veteran, name war: No
3. (c) Social Security No.: none
4. Sex: F.
5. Color or race: W.
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Milton D. Welch
6. (c) Age of husband or wife if alive: Dec years
7. Birth date of deceased: 3 (Month) 12 (Day) 1865 (Year)
8. AGE: Years 79 Months 8 Days 27 If less than one day ✓ hr. ____ min.
9. Birthplace: Indiana (City, town, or county) (State or foreign country)
10. Usual occupation: at Home
11. Industry or business: Indiana
MOTHER FATHER
12. Name: Henry Hamilton
13. Birthplace: Ind. (City, town, or county) (State or foreign country)
14. Maiden name: Mary Lechrest
15. Birthplace: Ind. (City, town, or county) (State or foreign country)
16. (a) Informant: C. C. Welch
(b) Address: 3918 Wyandotte K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/11/44 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Mariah, K.C. Mo.
18. (a) Signature of funeral director: Stine & McClure
(b) Address: Kansas City, Mo.
19. (a) 12-11-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 9 year 1944 hour 6 minute P M.
21. I hereby certify that I attended the deceased from Dec, 1943, to Dec 9, 1944, that I last saw h. ____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Failure
Due to: Myocardial Degeneration
Hypertension & Senility
Due to:
Other conditions (Include pregnancy within 3 months of death): 93 8

Duration

Major findings:
Of operations:
Of autopsy: none

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: P. H. Ouzen (M. D. or other)
Address: 103 4 Rockbeary Ill. Date signed 12/11/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. H. Owens
Bolts Body 2/2

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 [signature]

Licensed Embalmer No. 1415

P. O. Address R. C. 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.