

FILED JAN 1 1945

Registration District No. **29**

Primary Registration District No. **3049**

Registrar's No. **197**

1. PLACE OF DEATH:

(a) County **Nodaway**
 (b) City or town **Maryville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St Francis
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **36 hrs.**
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mary Louisa Welch**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **5** **9** **1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 **7** **8** _____ hr. _____ min.

9. Birthplace **Carlenville** **Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **John Welch**
 13. Birthplace **Unknown** **Ill.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown** **Unknown**
 15. Birthplace **" "** **" "**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Kate Miller**

(b) Address **Rock Port, Mo.**

17. (a) **Burial** (b) Date thereof **12-16-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenhill Cem.**

18. (c) Signature of funeral director **Bartholomew Montuoz**

(b) Address **Rock Port, Mo**

19. (a) **Dec. 18, 1944** (b) **Ann Barber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Atchison**
 (c) City or town **Rock Port**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **1** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **15**
 year **1944** hour **12** minute **30** A. M.

21. I hereby certify that I attended the deceased from **Dec 12**
 19 **44** to **Dec 15** 19 **44**
 that I last saw **her** alive on **Dec 14** 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cornyary sclerosis not known**

Due to **general arteriosclerosis not known**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **94a**
 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 **1**

23. Signature **A. Bleumer** (M. D. or other) _____
 Address **Maryville Mo** Date signed **12/16/44**

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

1549

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 Graf Bartholomew
Licensed Embalmer No. 3173
P. O. Address Rock Point, 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.