

S. No. 2
M-8-43
S-17-39
P 1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

32948

FILED NOV 7 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4341

1. PLACE OF DEATH:

(a) County Jackson City
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Moys Rest Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 years
(Specify whether _____)
In this community 5 years
years, months or (days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Austin Mo (b) County Cass 19
(c) City or town Austin 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No 1
If yes, name country _____

3. (a) PRINT FULL NAME

Anna Sarah Welden

(b) If veteran, name war no (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1945 hour 1 P.M. minute 0 P.M.
21. I hereby certify that I attended the deceased from Sept 26
1945 to Oct. 20 1945

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow's
(b) Name of husband or wife James Welden 6. (c) Age of husband or wife if deceased 17
7. Birth date of deceased: Out 17 (Month) 1860 (Day) (Year)

that I last saw her alive on Oct. 18 1945
and that death occurred on the date and hour stated above.
Immediate cause of death acute bronchitis 1 was

8. AGE: Years 85 Months 0 Days 3 If less than one day _____ hr. _____ min.

Due to chronic myocarditis yrs.
Due to _____

9. Birthplace Quebec Canada?
(City, town, or county) (State or foreign country)

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

10. Usual occupation housewife

Major findings: _____
Of operations none 93rd

11. Industry or business deceased

Of autopsy none

12. Name Rev. H. H. Tompkins

13. Birthplace No record 9
(City, town, or county) (State or foreign country)

14. Maiden name No record 9

15. Birthplace No record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dornice Witt
(b) Address 2425 Harvesty St. No

17. (a) Burial (b) Date thereof Oct. 22 45
(Burial or cremation) (Month) (Day) (Year)
(c) Place: burial or cremation: Justin Cemetery

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? _____

18. (a) Signature of funeral director Wm. Buss
(b) Address Karnesville Mo
19. (a) 10-22-45 (b) Cheradine Holme
(Date received local registrar) (Registrar's signature)

(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature Maryann Jones (M. D. or other) _____
Address 38 39th St. K. C. Mo Date signed 10-22-45

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 ^{Not} embalmed ~~by~~, or by

....., Registered Apprentice No.
working under my personal supervision.

Signed

Floyd Atkinson

Licensed Embalmer No.

3920

P. O. Address

Parisville 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.