

Registration District No. 149

Primary Registration District No. 1002

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: St. Lukes Hospital  
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 2 da.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Fairville  
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. 1 #2 Austin Lake  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cathy Ann Welch

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 4 22 1947  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Andrew Welch

13. Birthplace Eric Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Elizabeth Manley

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

16. (a) Informant Mrs. J. A. Welch

(b) Address Rt. 1 #2 Austin Lake Fairville

17. (a) Removal (b) Date thereof 4-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield mo.

18. (a) Signature of funeral director Will Burreal Home While at work? \_\_\_\_\_ (Specify type of place)

(b) Address Brookfield mo. Means of injury \_\_\_\_\_

19. (a) 4-25-47 (b) Thelaine Holmes 23. Signature D. C. V. Smith (M.D. or other) M.P.  
(Date received local registrar) (Registrar's signature) Address St. Luke Hospital Date signed 25 April 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24<sup>th</sup> year 1947 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from 4-22 1947 to 4-24 1947 that I last saw her alive on 4-24 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Prenatality 6 1/2 months pregnancy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 159

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? 0

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

18  
3  
8

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**