

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED JAN 14 1952

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>5134</u>		Registrar's No. <u>13</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Washington TWP</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Washington Twp.</u>		<u>0110</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route 7 St. Joseph</u>				d. STREET ADDRESS (If rural, give location) <u>Route 7 St. Joseph</u>			
3. NAME OF DECEASED (Type or Print) <u>Harriett</u>		a. (First)		b. (Middle)		c. (Last) <u>Welsch</u>	
4. DATE OF DEATH <u>Jan. 1, 1952</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Nov. 26, 1881</u>		9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>0</u>		IF UNDER 1 YEAR Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Grazier</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda McDonald</u>		14. NAME OF HUSBAND OR WIFE <u>Mike Welsch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mike Welsch Route 7, St. Joseph</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Met. Car. Caecoma of lungs-</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma Breast</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>8/30/52</u> <u>1 yr-</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		<u>170X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/30</u> <u>1951</u> , to <u>12/31</u> , <u>1951</u> , that I last saw the deceased alive on <u>12/31</u> , <u>1951</u> , and that death occurred at <u>7:30a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Frank Sandigan MD</u>		(Degree or title)		23b. ADDRESS <u>620 Kansas St.</u>		23c. DATE SIGNED <u>1/2/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-4-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 9, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Sidusader</u>		ADDRESS <u>1802 Union St</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

110  
1

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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed.....

Student Embalmer No.....  
*Robert H. Gable*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.