No. 300
10.48

FILED MAY 4 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13940
State File No.

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO 5691 Registrar's No. 54

1. PLACE OF DEATH
a. COUNTY: Laclede, LINN
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Laclede RFD
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): [redacted]

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: LINN
c. CITY OR TOWN: Laclede
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): RFD 0530

3. NAME OF DECEASED (Type or Print)
a. (First): Lula
b. (Middle):
c. (Last): Welsh

4. DATE OF DEATH (Month) (Day) (Year): April 30 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 2, 1879
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months 11 Days 28 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Sam E McKisson
13b. MOTHER'S MAIDEN NAME: Ella Kelsey
14. NAME OF HUSBAND OR WIFE: Cecil Welsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: Cecil Welsh
ADDRESS:

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 260X
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James B. McClellan Coroner
23b. ADDRESS: Brookfield Mo
23c. DATE SIGNED: 4/30/56

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: May 2-1956
24c. NAME OF CEMETERY OR CREMATORY: Laclede
24d. LOCATION (City, town, or county) (State): Laclede

DATE REC'D BY LOCAL REG.: 5-1-56
REGISTRAR'S SIGNATURE: Kathalene Johnson Dep.
25. FUNERAL DIRECTOR'S SIGNATURE: J B Brothers
ADDRESS:
(Licensed Embalmer's Statement on Reverse Side)

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

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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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Marion E. Millian

Licensed Embalmer No. 39

P. O. Address Meadville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.