V.S. No. 300
Rev. 10.48

Dr. McDaniel
FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36838

BIRTH NO. _____ REG. DIST. NO. 272 PRIMARY REG. DIST. NO. 5906 Registrar's No. 49

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

1. PLACE OF DEATH
a. COUNTY: Pemiscot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Steele Walling
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): Hallard Bros

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Pemiscot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Steele
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): Wayne
c. (Last): Welch

4. DATE OF DEATH (Month) (Day) (Year): 10-13-57

5. SEX: M
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7-9-1957
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 3, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): Steele Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: James L Welch
13b. MOTHER'S MAIDEN NAME: Carrie Mae Stingley
14. NAME OF HUSBAND OR WIFE: —

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.:
17. INFORMANT'S SIGNATURE OR NAME: James L Welch — ADDRESS: Steele Rt 1

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): Pneumonia

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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 493X
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* 10-11, 1957, *to* 10-11, 1957, *that I last saw the deceased alive on* 10-11, 1957, *and that death occurred at* 2:P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H F McDaniel MD
23b. ADDRESS: Steele Mo
23c. DATE SIGNED: 10-18-57

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-14-57
24c. NAME OF CEMETERY OR CREMATORY: Holly Grove
24d. LOCATION (City, town, or county) (State): Steele Mo

DATE REC'D BY LOCAL REG.: 11-1-57
REGISTRAR'S SIGNATURE: Thomas C Dunlop
25. FUNERAL DIRECTOR'S SIGNATURE: German Undt Co — ADDRESS: Steele Mo

249
0

(Licensed Embalmer's Statement on Reverse Side)

10-306-57

OCT 30 1957

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

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 Not Embalmed Student Embalmer No. ....., working under my personal supervision.

Student ..... Student Embalmer

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.