

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005958  
STATE FILE NUMBER

FILED MAR 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 954

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Length of stay in 1b -31 YEARS	d. STREET ADDRESS (If outside, give location) 7615 Main Street
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last DORIS JEANNE WELCH			4. DATE OF DEATH Month Day Year February 18, 1959		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1911	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	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 country) SPEARVILLE, KANSAS	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	--	--

13a. FATHER'S NAME GLEN E. WEYAND	13b. MOTHER'S MAIDEN NAME IVERD ABRAHAM	14. NAME OF HUSBAND OR WIFE Oliver D. Welch
--------------------------------------	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 500-28-7266	17. INFORMANT Address Oliver D. Welch, 7615 Main St., K.C. MO
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asophagial varices &amp; hemonhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hours</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Cirrhosis of the liver</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
--	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	---

21. I attended the deceased from <i>27 July 1952</i> to <i>18 Feb 1959</i> and last saw her alive on <i>17 Feb 1959</i> Death occurred at <i>6:15</i> <i>A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>Blaine Z. Hibbard MD</i>	22b. ADDRESS <i>411 Nichols Rd K.C. Mo</i>	22c. DATE SIGNED <i>18 Feb 59</i>
---	---	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Feb. 19, 1959	23c. NAME OF DEATH HOME OR CREMATORY D.W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	----------------------------	--	--

24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C., Mo.	25. DATE RECD. BY LOCAL REG. <i>2-19-59</i>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
---	--	---

All diseases in Part I must be causally related.

Blaine Z. Hibbard MD

MEDICAL CERTIFICATION

300  
1-57

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed ..... *C. P. Nelson* .....

Licensed Embalmer No. *4481* .....

P. O. Address *Kansas City* .....

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

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