

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047047

FILED VS DEC 19 1960

Registration District No. 274 Primary Registration District No. 3152 Registrar's No. 424

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>SEDALIA</u>		Length of stay in 1b <u>20 DAYS</u>		c. CITY OR TOWN <u>STOVER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>BOTHWELL Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2 RD. STREET</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGIA</u> Middle <u>MARK</u> Last <u>WELPMAN</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7 1899</u>	
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>		IF UNDER 24 HR Hours <u></u> Min. <u></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 <u>SAFAYETTE CO. MO.</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>ERNEST J. MEYER</u>			13b. MOTHER'S MAIDEN NAME <u>ANNA DRIVER</u>			14. NAME OF HUSBAND OR WIFE <u>HENRY K WELPMAN</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 <u>ALVA SMALL STOVER MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>							
DUE TO (c) <u>Cerebral Arteriosclerosis</u>							<u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u>1957</u>					
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 <u>STOVER, MO</u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>1957</u> to <u>Dec 12th</u> and last saw her alive on <u>Dec 11th</u> Death occurred at <u>2:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>D.C. Koffa D.O.</u>				22b. ADDRESS <u>Stover, Mo</u>		22c. DATE SIGNED <u>12/15/60</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC. 15 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>STOVER CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>STOVER MO.</u>	
24. FUNERAL DIRECTOR <u>Schwenner-Stevenson</u>		ADDRESS <u>Stover Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. L. Stevenson

Licensed Embalmer No. 4073

P. O. Address Lower Va

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.