N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34734
Do not use this space.

REC'D NOV 21 1938

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kans
(c) City Kansas City
Registration District No. 355
Primary Registration District No. 1602
Registered No. 4070
(d) Street No. St. Lukes Hosp. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Columbus Welsh
(a) Residence, No. 3671 Summit St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Mabelle Welsh

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 9. 1854

7. AGE: Years 84 | Months 8 | Days 8 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Carpenter Con.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Phila. Penn.

FATHER
13. NAME James Welsh
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

MOTHER
15. MAIDEN NAME Mary -----
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Hurtle Forcade
(ADDRESS) 3671 Summit, K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL Burial
PLACE Mt. Moriah DATE 10/19/38, 19

19. FUNERAL DIRECTOR (NAME) H. F. Mayberry
(ADDRESS) 2315 Linwood Blvd. K. C. Mo.

20. FILED Oct. 18, 1938 M. M. Crome
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/17/38, 19

22. I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1938 to Oct. 17, 1938
I last saw him alive on Oct. 17, 1938. Death is said to have occurred on the date stated above, at 5:00 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uremia due to Chronic Interstitial Nephritis	

Other contributory causes of importance:
Hypostatic Pneumonia
Enterocolitis

Name of operation ..... Date of .....
What test confirmed diagnosis? Physical Exam. Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? —— Date of injury ....., 19....
Where did injury occur? ——
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ——
Nature of injury ——

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) [illegible] M.D.
(Address) [illegible] K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.