

REC'D JUL 15 1939

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

22321

Do not use this space.

1. PLACE OF DEATH

 (a) County Jackson
 (b) Township Ft Osage
 (c) City Levasy
Registration District No. 396Primary Registration District No. 5552

Registered No. _____

 (e) Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

 (a) Residence, No. 436 HENRY WELTER
Levasy Missouri

(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. Wilhemena Welter
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 5th. 1864
 7. AGE YEARS 74 MONTHS 9 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. farmer
 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) Holstein Missouri

 PATHER 13. NAME Christian Welter

 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

 MOTHER 15. MAIDEN NAME Louise Katherine Flothman

 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

 17. INFORMANT (ADDRESS) Julius Wieter Levasy Mo.

 18. BURIAL, CREMATION, OR REMOVAL PLACE Levasy Cemetery DATE June 6 1939

 19. FUNERAL DIRECTOR (NAME) (ADDRESS) V. M. Reppert Buckner Mo.

 20. FILED June 6 1939 John W. Robertson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 4 193922. I HEREBY CERTIFY, That I attended deceased from May 4 1939 to June 4 1939
 I last saw him alive on June 3, 1939. Death is said to have occurred on the date stated above, at 4:30 m. P.M.

The principal cause of death and related causes of importance were as follows:

Acute cystitis

Date of onset

Other contributory causes of importance:

Fracture Surgical Neck femurName of operation none Date of _____What test confirmed diagnosis? clinical Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? X Date of injury X, 19____

 Where did injury occur? X (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Manner of injury XNature of injury X24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) John W. Robertson, M. D.(Address) Buckner Mo.

1946

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,

D. M. Reppert

....., or by

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

Signed.....

D. M. Reppert

Licensed Embalmer No. *2321*

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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1. PLACE OF DEATH

(a) County Jackson Registration District No. 396
 (b) Township H. George Primary Registration District No. 5-82 Registered No.
 (c) City (d) Street No. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henry Welter

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 2 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19...

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-4, 1939

22. I HEREBY CERTIFY, That I attended deceased from to

I last saw h..... alive on, 19..... Death is said to have occurred on the at..... m.

The principal cause of death and related causes of importance were as follows:

acute cystitis

Date of onset

Other contributory causes of importance:

fracture surgical neck femur

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury May 4, 1939
 Where did injury occur? Jones, Jackson Co. Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall on floor
 Nature of injury Fracture of surgical neck femur

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Jones W. Robertson, M. D.
 (Signed) Buelmer
 (Address) Jones

SUPPLEMENTARY

WHILE FILLING IN, WITH UNFADING INK--THIS IS A PERMANENT RECORD
 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.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

