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4-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9605**
Registrar's No. **1014**

FILED APR 15 1941
Registration District No. **299**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson,**
(b) City or town **Kansas City,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6109 Rockhill Road,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.**
(Specify whether
In this community **all her life,**
years, months or days)

2. USUAL RESIDENCE OF DECEASED: **48**
(a) State **Missouri,** (b) County **Jackson,**
(c) City or town **Kansas City,**
(If outside city or town limits, write "RURAL")
(d) Street No. **6109 Rockhill Road,**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **No.** years.

3. (a) PRINT FULL NAME **Miss Leila A. Welsh,**
3. (b) If veteran, name war **no.**
3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **9th**
year **1941** hour **Early** minute **A.** M.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single,**
6. (b) Name of husband or wife **X**
6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased: **November 7, 1916**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Crump**
to **19** to **19**;
that I last saw him alive on **19**;
and that death occurred on the date and hour stated above.
Immediate cause of death **Acute hemorrhagic**
Duration

8. AGE: Years Months Days If less than one day
24 **4** **2** hr. min.

Due to **Massive wound of neck**
Due to _____

9. Birthplace **Missouri,** (City, town, or county) (State or foreign country)
10. Usual occupation **at home,**
11. Industry or business **X**

Other conditions (Include pregnancy, pending work of death)
Fracture of the skull
Major findings: Of operations _____
Of autopsy **See above.** **11/17**
PHYSICIAN _____

MOTHER FATHER {
12. Name **George W. Welsh,**
13. Birthplace **Kentucky,** (City, town, or county) (State or foreign country)
14. Maiden name **Marie Fleming,**
15. Birthplace **Missouri,** (City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. George W. Welsh,**
(b) Address **6109 Rockhill Road, K. C., Mo.**
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **3-11-41**
(Month) (Day) (Year)
(c) Place: burial or cremation **Carrollton, Mo.**
18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**
19. (a) **Nov 11, 1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Homicide**
(b) Date of occurrence **3/9/41**
(c) Where did injury occur **6109 Rockhill Rd K. C. Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? **no.** (Specify type of place) **Premises with**
(c) Means of injury **knife and hammer**
23. Signature **C. J. Welsh** (M. D. or other) **3/11/41**
Address **K. C.** Date signed **3/11/41**

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.....

Willis H. Bennett, Registered Apprentice No. 282
working under my personal supervision.

Signed

E. M. Plank

Licensed Embalmer No. 1848

P. O. Address T. C. Mo.

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.