

No. 2  
1-4-41  
17-39  
X25390

DEC 22 1941 399

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. 4120

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K. C. Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ben Hayes 5th & Locust  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 hr.  
In this community 1 hr.  
years, months or days

3. (a) PRINT FULL NAME Elmer E Welker

3. (b) If veteran, name war — 3. (c) Social Security No. no

4. Sex OM 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lula 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased. Oct 14 1884  
(Month) (Day) (Year)

8. AGE: Years 57 Months 20 Days — If less than one day — hr. — min.

9. Birthplace. Carroll County Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Martin Welker

13. Birthplace Unknown 0  
(City, town, or county) (State or foreign country)

14. Maiden name Vera Cox

15. Birthplace Caldwell County Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lula Welker

(b) Address Rt. 1 Carrollton Mo

17. (a) removal (b) Date thereof. 11/5/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Braymer, Mo

18. (a) Signature of funeral director Sehbet's

(b) Address 901 E 5th

19. (a) 11-5-41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll 17  
(c) City or town Carrollton  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. #1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes: name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4 1941  
year — hour — minute 7:50 P.

21. I hereby certify that I attended the deceased from 7:50 P.  
that last saw Deputy Coroner  
and the death occurred on the date and hour stated above.  
Immediate cause of death Subdural or subarachnoid cerebral  
Duration 170

Due to hemorrhage  
fracture of the skull  
Auto traumatism  
Other conditions 170  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations —  
Of autopsy Yes

PHYSICIAN  
—  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 11-4-41

(c) Where did injury occur? K.C. no 123  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
—

While at work — (Specify type of place) Means of injury —

23. Signature Carrollton (M. D. or other)  
Address K.C. Mo Date signed —

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

MOTHER FATHER

---

**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.....

*Guys Rubenstone*

.....  
Licensed Embalmer No. *12759*

P. O. Address.....  
*CCMO*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37326  
Registrar's No. 4120

Registration District No. 399

Primary Registration District No. 102

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Ernie C. Welker

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. 14, 1887  
(Month) (Day) (Year)

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11/5/42 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Collision

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY 4

S-37326