

FILED JUN 7 1943
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2072

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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 1 day
(Specify whether _____)

In this community 19 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Kansas City ³
(If outside city or town limits, write "RURAL")

(d) Street No. 3509 Lexington ⁸
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) ⁰
If yes, name country _____

3. (a) PRINT FULL NAME Opal Welch

3. (b) If veteran, name war --

3. (c) Social Security No. -- none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd
year 1943 hour 7 minute 30 A.M. M.

4. Sex F | 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas Walter Welch

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased April 6, 1900
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-1-43 to 5-2-43, 19____;
er 5-2-43, 19____;
that I last saw h. alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>0</u>	<u>26</u>	_____ hr. _____ min.

Immediate cause of death Carcinoma of lungs

Due to _____

Due to _____

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

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Housewife

11. Industry or business _____

12. Name Orie Loffer

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

14. Maiden name Mary May Vaughn

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

16. (a) Informant Orie Loffer

(b) Address Cillicothe, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 4, 43
(Month) (Day) (Year)

(c) Place: burial or cremation La Cygne, Kansas

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Aye. K.C. Mo.

19. (a) 5-3-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

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? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature Dr. R. Shon (M. D. or other) _____

Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.