

FILED MAR 10 1944

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 418

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Mo. State Hospital No. 1, 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months, 0 days  
(Specify whether)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALMA WELCH

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased October 2 1888  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13  
year 1944 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from November 4 1943 to February 13 1944  
that I last saw her alive on February 13 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

Years	Months	Days	If less than one day
<u>55</u>	<u>4</u>	<u>11</u>	hr. _____ min.

Immediate cause of death Cerebral hemorrhage, Neuripoplegia

Due to Hypertension, Cardio-renal disease

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

Other conditions Heart, Stomach  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Teacher

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

Of autopsy No autopsy.

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

MOTHER FATHER {

11. Industry or business \_\_\_\_\_

12. Name Orril G. Welch

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

14. Maiden name Inez Campbell

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 2-15-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Missouri

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

(b) Address Kansas City, Missouri

19. (a) Feb 24 1944 (b) Byrdie Bukhmaster  
(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) \_\_\_\_\_

(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) (e) Means of injury 0

23. Signature M. J. Taylor (M. D. or other) Physician

Address 408 W. E. Smith Date signed 2-22-44

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

1196

RECEIVED

District Health Officer No. 4  
District File Number 344-3467  
Date Filed 3-7-44

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 C. H. Cozen

Licensed Embalmer No. 4084

P. O. Address Farmington

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.