

S. No. 2
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31582

State File No.

FILED OCT 9 1944

Registration District No. 295

Primary Registration District No. 4442

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Higbee Mo.
(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 8 Yrs 10 Mo 3 da. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Higbee Mo.
(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 Sept. day 1
year 1944 hour 12 minute 25 a. M.
21. I hereby certify that I attended the deceased from aug 25
1944 to aug 31 1944
that I last saw him alive on aug 31 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Paralysis cerebral 3 day

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy no
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) _____
(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? _____

(Specify type of place)
While at work _____ (e) Means of injury _____
23. Signature [Signature] (M. D. or D. O. M.)
Address [Address] Date signed 9/13/44

3. (a) PRINT FULL NAME Frank Welch.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Black
6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 10 1862
(Month) (Day) (Year)

8. AGE: Years ' Months Days If less than one day
81 10 3 _____ hr. _____ min.

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

10. Usual occupation Retired Worker.

11. Industry or business _____

12. Name George Welch

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

14. Maiden name Dont Know

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

16. (a) Informant Lawrence Welch.
(b) Address Higbee Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Col. Cem. Higbee Mo

18. (a) Signature of funeral director Joe W Burton
(b) Address Higbee Mo.

19. (a) Sept 10, 1944 (b) [Signature] (Registrar's signature)
(Data received local registrar)

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

1027

RECEIVED

District Health Officer No. 10

District File Number 10-44-166

Date Filed OCT 6 1944

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.....

J.P.M. Crary

Licensed Embalmer No.....

3153

P. O. Address.....

Glasgow 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.