

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registration District No. 59 Primary Registration District No. 4105
Registrar's No. 60

1. PLACE OF DEATH:
(a) County CASS
(b) City or town PECULIAR
(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 1
In this community 20 YEARS
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County CASS 19
(c) City or town PECULIAR
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY CASSANDRA WELBORN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. day 25
year 1946 hour 9 minute 25 P.M.
21. I hereby certify that I attended the deceased from April 18
1946 to April 25 1946
that I last saw her alive on April 25 1946
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife WALTER WELBORN
6. (c) Age of husband or wife if alive 8 years
7. Birth date of deceased April 1873
(Month) (Day) (Year)

Immediate cause of death
Cerebral thrombosis -
Due to Cerebral arteriosclerosis
Due to _____
Other conditions Endarteritis obliterans
(Include pregnancy within 3 months of death)

Duration 2 Days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

8. AGE: Years 73 Months 0 Days 17
If less than one day hr. _____ min. _____

9. Birthplace LAFAYETTE Co Mo. (U)
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER
12. Name WILLIAM S. CALLAWAY
13. Birthplace CARROLL Co Mo. (U)
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH P. WILLS
15. Birthplace TENN. (U)
(City, town, or county) (State or foreign country)

16. (a) Informant ELIZABETH WELBORN
(b) Address PECULIAR, MO.

17. (a) BURIAL (b) Date thereof APR 28 '46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PECULIAR CEM., PECULIAR MO.

18. (a) Signature of funeral director B. T. Thomas, Sauer
(b) Address Bethan Mo

19. (a) 4-30-46 (b) Laura J. Jones
(Date received local registrar) (Registrar's Name)

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 Marion V. Roberts (M. D. or other) MD
Address Peculiar, Mo Date signed 4/29/46

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

11439

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..... *A. K. George*

Licensed Embalmer No. *3675*

P. O. Address *Grandview, Md*

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.