

No. 2
 M-5-43
 5-17-39
 I X38671

FILED OCT 7 1946
 42

Registration District No. _____ Primary Registration District No. **1000**

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 1/2 Months**
18 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan** //
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **110 So. 15th**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Grace Welsh**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Sept.** day **27**
 year **1946** hour **8** minute **15** A.M.

4. Sex **Female**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Warren S. Welsh**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **April 5 1974**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 2** 19**45**, to **Sept 27** 19**46**
 that I last saw **her** alive on **Aug 6** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Heart disease** Duration **8 mo**

8. AGE:	Years	Months	Days	If less than one day
	72	5	22	hr. _____ min. _____

Due to _____
 Due to _____

9. Birthplace **Muncie Co. Illinois**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
12/10

10. Usual occupation **At Home**

11. Industry or business **Walter P. Finch**

12. Name _____
 13. Birthplace **Unknown Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary C. Neff**
 15. Birthplace **Unknown Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Warren Welsh**
 (b) Address **St. Joseph, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/23/46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Heaton Beale & Beckman**
 (b) Address **St. Joseph, Mo.**

19. (a) **Sept. 30, 1946** (Data received local registrar)
A. H. Heston (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 _____

23. Signature **Dr. H. J. Ferson** (M. D. or other) **Dr. Ferson**
 Address **St. Joseph, Mo.** Date signed **9-27-46**

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

MOTHER FATHER

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

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OCT 9 1946
JAN 23 1947

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 Raymond W. Morehead
Licensed Embalmer No. 4413
P. O. Address 319 So 10th Joseph

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.