

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 149

Primary Registration District No. 1002

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

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:
3320 Paseo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether)

In this community 48 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Katherine Welch

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex female / 5. Color or race white

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

6. (b) Name of husband or wife Bert W. Welch

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased: January 3 1868
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 11 If less than one day hr. min.

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

10. Usual occupation at home.

11. Industry or business X

MOTHER FATHER { 12. Name John McCauley

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

14. Maiden name unknown

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

16. (a) Informant Mr. Bert W. Welch

(b) Address 3320 Paseo, Kansas City, Mo.

17. (a) Burial (b) Date thereof 9-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery
Stine & McClure

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-17-48 (b) Seraldine Helme
(Date received local registrar) (Registrar's signature)

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. 3320 Paseo
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14
year 1948 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from Sept 12
1948 to Sept 14 1948

that I last saw her alive on Sept 14
and that death occurred on the date and hour stated above.

Immediate cause of death terminal
cardiac failure
terminal pneumonia
hypostatic

Due to coronary thrombosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Duration

3 days

PHYSICIAN

Major findings:
Of operations g3b

Of autopsy

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?

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

23. Signature [Signature] (M. D. or other) MD

Address 1014 Canby Date signed 9/15/48

C.
Dr. Harrison Trippe

Argyle Bldg. Sta 3454
around 12 o'clock.

11:30 or 12.

Leave in office

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.....

Robert H Reed

Licensed Embalmer No. 3745

P. O. Address 14C 5mo

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.