

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30655

3680

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1062 Registrar's No. 3680

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (in this place) life	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo.		d. STREET ADDRESS (If rural, give location) 344 So. Lawndale
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #1			d. STREET ADDRESS 344 So. Lawndale		
3. NAME OF DECEASED (Type or Print) Mamie			a. (First)	b. (Middle)	c. (Last) Welch
4. DATE OF DEATH (Month) (Day) (Year) Aug. 25 1949	5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED widowed	8. DATE OF BIRTH 8-21-1883	9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Warden		13b. MOTHER'S MAIDEN NAME Tula Davis		14. NAME OF HUSBAND OR WIFE John E.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Claude Lerner		ADDRESS Los Angeles, Ca	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio vascular accident				INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4221				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-22- , 19 49 , to 8-25- , 19 49 , that I last saw the deceased alive on 8-25-49 , 19 49 , and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE Wm W. Hart MD (Degree or title)			23b. ADDRESS Acting Med. Dir. Gen'l. Hosp.		23c. DATE SIGNED 8-26-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 8-27-49	24c. NAME OF CEMETERY OR CREMATORY Lee Summit Lee Summit Mo.	24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. 8-26-49	REGISTRAR'S SIGNATURE Sheraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE John R. Shiel ADDRESS R. C. Mc		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

.300
.48

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

John P. Scheil

Licensed Embalmer No. 36 25

P. O. Address H. C. Mc

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.