

FILED NOV 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38229

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 410

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	
c. LENGTH OF STAY (in this place) <u>8 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>1101 E. 16th st.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1101 E. 16th st.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Goldie</u> b. (Middle) <u>Welch</u> c. (Last) <u>Welch</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov - 24 - 1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>March 8 - 1899</u>		9. AGE (In years last birthday) <u>50</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Clarinda Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			

13a. FATHER'S NAME <u>William T. Crain</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Yapple</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Frank Welch</u> ADDRESS <u>Sedalia</u>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Thrombosis</u>		DUE TO (b) <u>Pulmonary T. B.</u>				15 yrs	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Generalized T. B. thru out body</u>				7.2 X	
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				20. AUTOPSY? YES <input 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) (Min.)		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 Nov 23, 1949, to Nov 24, 1949, that I last saw the deceased alive on Nov 24, 1949, and that death occurred at 9:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. H. L. Holder</u>		23b. ADDRESS <u>D.O.V. 3524 Old Sedalia Mo</u>		23c. DATE SIGNED <u>11/29/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-26-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	
24d. LOCATION (City, town, or county) <u>Sedalia</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>			
DATE REC'D BY LOCAL REG. <u>11-26-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager</u>		251 <u>251</u>	

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

80
627

RECEIVED NOV 28
District Health Officer No. 8,
District File Number _____
Date Filed 11-28-49

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 KPM Cray

Licensed Embalmer No. 3153

P. O. Address Salisbury, 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.