

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13907**

FILED MAY 4 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **425**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Mtn Grove, Mo 1141	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Luther	b. (Middle) A	c. (Last) Welch	4. DATE OF DEATH (Month) (Day) (Year) APRIL 25-1953
-------------------------------------	--------------------------	----------------------	------------------------	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-19-1900	9. AGE (In years last birthday) 53	# UNDER 1 YEAR Months 0 Days 36	# UNDER 24 HRS. Hour / Min. /
--------------------	-------------------------------	---	-----------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER + LABOR	10b. KIND OF BUSINESS OR INDUSTRY FARMER-LABOR	11. BIRTHPLACE (State or foreign country) Southern Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME MARSHALL WELCH	13b. MOTHER'S MAIDEN NAME MARY JANE PLASTER	14. NAME OF HUSBAND OR WIFE HETTIE BUSHONG
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Hettie Bushong	ADDRESS Mtn. Grove, Mo
--	--	---	-------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Valvular Ht. Disease with auricular fibrillation + cerebral embolus		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (Rheumatic)		
	DUE TO (b) /		
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 4214	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **4/21**, 19**53**, to **4/25**, 19**53**, that I last saw the deceased alive on **4/21**, 19**53**, and that death occurred at **2 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Miss D Callaway	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 4/27/53
---	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-28-53	24c. NAME OF CEMETERY OR CREMATORY STUBBS	24d. LOCATION (City, town, or county) (State) MTN GROVE Mo.
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. 4-28-53	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE BARBER FUNERAL HOME	ADDRESS Mtn Grove
---	---	---	--------------------------

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

396

0028

111

111

2000

2000

2000

JUL 27 1954

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 Rev. Barber

Licensed Embalmer No. 3848

P. O. Address 9th St. / Home

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.