

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 20 1957

STATE FILE NUMBER **4091**

Registration District No. 74 Primary Registration District No. 5295 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits or TOWNSHIP only) Inside Limits OR TOWN <u>Plattsburg, Concord Twp</u> Y LI No <u>0</u>		c. CITY OR TOWN <u>Plattsburg</u> - 0250 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>Lewis Rest Home</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>Lewis Rest Home</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Mileham Welsh</u>			4. DATE OF DEATH Month Day Year <u>JAN 14 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1869</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Rural - Illinois 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Welsh</u>			14. MOTHER'S MAIDEN NAME <u>Annie Stivers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No. X X</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs R. Mac Rupe Trimble, Mo.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>Jan 11 1957</u> to <u>Jan 14 57</u> and last saw her alive on <u>Jan 19-57</u> Death occurred at <u>7:30 a.m.</u> on the date stated above; and to the best of my knowledge from the causes stated.		
22a. SIGNATURE (Doctor or title) <u>W. B. ...</u>	22b. ADDRESS <u>Plattsburg Mo</u>	22c. DATE SIGNED <u>Jan 14 57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>
23d. LOCATION (City, town, or county) (State) <u>Clinton County Mo.</u>		

24. FUNERAL DIRECTOR ADDRESS <u>D. D. Lyon Plattsburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 19, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Elizabeth Scarce</u>
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(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in Part I.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....  
Signature of Student Embalmer

Signed *Reeja B. God*.....

Licensed Embalmer No. *49*

P. O. Address *South*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.