

Health,  
& Welfare  
Public  
Service

300  
1-57

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40658  
STATE FILE NUMBER  
3582  
Registrar's No.

FILED DEC 11 1957

Registration District No. 149 Primary Registration District No. 1002

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Kansas City</b>  |                                  | c. CITY OR TOWN <b>Kansas City</b>  |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                                  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>422 1/2 Truman Ref. Hse</b>   |                                  | d. STREET ADDRESS (If outside, give location)<br><b>422 1/2 Truman Ref. Hse</b>   |   |
| Length of stay in lb  |                                  | Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Harold H. Welch</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>11-13-1957</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 13, 1918</b>  |
| 9. AGE (In years, months, days, hours, minutes)<br><b>39</b>  |                                  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (City and state or country)<br><b>Grand Rapids, Mich</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  | 13a. FATHER'S NAME<br><b>Arthur Welch</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Corrine Casey</b>   |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>Allet Welch</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>376-16-1422</b>   |   |
| 17. INFORMANT<br><b>Veterans Adm. K.C., Mo.</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cause of death unknown</b>                                      |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>795#</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Natural Death</b>   |                                  |   |   |
| 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.)  |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |                                  | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Hugh H. Owens</b>  |                                  | 22b. ADDRESS<br><b>1134 Kialto Blvd</b>   |   |
| 22c. DATE SIGNED<br><b>11-15-57</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo. Kans</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>11-27-57</b>     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hall Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo. Kans</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Peter B. Lapetina, K.C., Mo.</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>11-25-57</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Reva Myrshall</b>   |                                  |   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Owens  
Hugh H.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *[Handwritten Signature]*

Licensed Embalmer No. 4273  
P. O. Address K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.