

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044810

STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 148

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1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Laclede 0580 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Brookfield Nursing Home Length of stay in lb 18mos		d. STREET ADDRESS (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Retta Welsh			4. DATE OF DEATH Month Day Year 12-21-1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 87
11. BIRTHPLACE (City and state or country) Carthage, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John B. Reno		14. MOTHER'S MAIDEN NAME Sarah Bates	
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.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary athermia.</i> DUE TO (b) <i>arteriosclerotic heart disease.</i> DUE TO (c) <i>Generalized arteriosclerosis with coronary athermia.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>A.O.A.</i> <i>2 yrs.</i>
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.) <i>4200</i>		
20c. TIME OF INJURY Hour: Month, Day, Year a. m. p. m.	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 <i>11-12-54</i> to <i>12-21-58</i> and last saw her alive on <i>12-21-58</i> . Death occurred at <i>4:30 p. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. W. Dobson M.D.</i> (Degree or title)	22b. ADDRESS <i>Brookfield, Mo.</i>	22c. DATE SIGNED <i>12/23/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-23-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Laclede Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Laclede, Missouri</i>
24. FUNERAL DIRECTOR <i>R. B. Gliddens</i> ADDRESS <i>Laclede, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>12-24-58</i>	26. REGISTRAR'S SIGNATURE <i>Katharine Johnson</i>	

(Licensed Embalmer's Statement on Reverse Side)

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..... *Blake Glidden*

Licensed Embalmer No. *5*

P. O. Address *Las Vegas*

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.