

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001568

STATE FILE NUMBER

242

JAN 28 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
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) HOSPITAL OR INSTITUTION Research		d. STREET ADDRESS 2610 Amie Court	
Length of stay in lb 58 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE Christine WELCH			4. DATE OF DEATH Month Day Year 1 13 59
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1881
9. AGE (In years (year birthday)) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Carrollton, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Geo. Washington Thomas	13b. MOTHER'S MAIDEN NAME Margaret Scott	14. NAME OF HUSBAND OR WIFE Benjamin L. Welch	
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. 492-14-1901	17. INFORMANT Hal. H. Welch, Grand Island, Neb.	
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>Generalized Carcinomatosis</i>			INTERVAL BETWEEN ONSET AND DEATH 6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma fundus uterini</i>			3 year
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertension C.V. disease & decomposition</i>			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.) ITEM 23b CORRECTED		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	BY AFFIDAVIT OF <i>Funeral Director</i> 3-20-59		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>11-10-1948</i> to <i>Jan 13 1959</i> and last saw her alive on <i>Jan 12 1959</i> Death occurred at <i>5:30 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Frank B. Leitz M.D.</i>		22b. ADDRESS <i>1530 Park Blvd. Kansas City, Mo</i>	22c. DATE SIGNED <i>11-13-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-13-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Moriah Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo.</i>
24. FUNERAL DIRECTOR <i>Wagner Funeral Home. K C Mo</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>1-13-59</i>	26. REGISTRAR'S SIGNATURE <i>Neve Marshall</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Frank B. Leitz

All diseases in Part I must be causally related.



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1-100

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 *Thomas A. Kehler*

Licensed Embalmer No. *4775*

P. O. Address *D.C. Md.*

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.