MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-033266

STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 489

FILED OCT 10 1961

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Independence — Length of stay in 1b: 12 Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Independence San.&Hospital — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Independence — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 3717 South Pleasant — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Albert Middle: C Last: Welch
4. DATE OF DEATH: Month: Sept Day: 21 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 3-3-1877
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Agent
10b. KIND OF BUSINESS OR INDUSTRY: Retired Railroad
11. BIRTHPLACE (City and state or country): Maquokita Iowa
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Boish Welch
13b. MOTHER'S MAIDEN NAME: Elizabeth Cuppy
14. NAME OF HUSBAND OR WIFE:
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: Mrs Glen E.Densmore Address: 3717 S.Pleasant

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ~~Throat~~ METASTATIC CARCINOMA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA of PROSTATE
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 ~~9-20-61~~ 1-20-61, to 9-20-61 and last saw her him alive on 9-20-61
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): George Caron MD
22b. ADDRESS: 10901 WINNER Rd
22c. DATE SIGNED: 9-21-61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept 23, 1961
23c. NAME OF CEMETERY OR CREMATORY: Mound Grove Cemetery
23d. LOCATION (City, town, or county) (State): Independence Missouri
24. FUNERAL DIRECTOR ADDRESS: Roland R Speaks Funeral Home Independence
25. DATE RECD. BY LOCAL REG.: 9-23-61
26. REGISTRAR'S SIGNATURE: Alba L. Craig

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — DOCUMENT

JUN 4 1963

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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Ludlow, M

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.