

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035918

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

38 Primary Registration District No. 3006 Registrar's No. 658

STATE FILE NUMBER

AMENDED

Registration District No. FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>2 Days</u>		c. CITY OR TOWN <u>Kahoka</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Location Unknown</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Myrtle Hobb Welch</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1961</u> <u>Feb 21 1909</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-1909</u>	
9. AGE (last birthday) <u>52 years</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state of country) <u>Clark, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>United States</u>							
13a. FATHER'S NAME <u>Jack Hobb</u>				13b. MOTHER'S MAIDEN NAME <u>Mariah Zwilling</u>		14. NAME OF HUSBAND OR WIFE <u>James Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>University of Mo. Medical Records Columbia, 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>Asphyxia</u> DUE TO (b) <u>aspiration of gastric contents</u> DUE TO (c) <u>Acute Gastric Dilatation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Exogenous Obesity = hypoventilation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 min</u> <u>4 min</u> <u>8-12 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
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, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>10-29-61</u> to <u>10-31-61</u> and last saw her/him alive on <u>10-31-61</u> Death occurred at <u>6:32 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>RE Lehman MD</u>				22b. ADDRESS <u>ummc columbic mo</u>		22c. DATE SIGNED <u>10-31-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11-1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia</u>		23d. LOCATION (City, town, or county) (State) <u>Kahoka Mo</u>	
24. FUNERAL DIRECTOR <u>Parker Funeral Serv Co</u>				25. DATE RECD. BY LOCAL REG. <u>Nov 11, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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

J. W. Phillips

Licensed Embalmer No. 11897

P. O. Address Columbus, 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.