

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035373

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 0000407 Registrar's No. 442

**FILED OCT 4 1963**

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>White Water Township</u>		Length of stay in 1b	c. CITY OR TOWN <u>Millersville Rt 3 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Near Millersville</u>	
3. NAME OF DECEASED (Type or print) First <u>AMOS</u> Middle <u>Crawford</u> Last <u>Welker</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1963</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1870</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>22</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Millersville Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Welker</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Mayfield</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Bedwell Dec.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-42-2947</u>	17. INFORMANT <u>Opal Welker Millersville 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> virus Cold</u> DUE TO (b) <u>Senility 794</u> DUE TO (c) <u>780-795</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1-19-63</u>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)			
20c. TIME OF INJURY. Hour <u></u> a.m. <u></u> p.m. <u></u>	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>June 26 63</u> to <u>Sept 27 63</u> and last saw him alive on <u>9-27-63</u> Death occurred at <u>8:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>D. L. Jackson M.D.</u>			22b. ADDRESS <u>Jackson Mo</u>		22c. DATE SIGNED <u>9-28-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-29-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Salem Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>4 Mi. n. Millersville</u>		
24. FUNERAL DIRECTOR <u>Deneke-Laird Jackson Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 2-1963</u>	26. REGISTRAR'S SIGNATURE <u>Deneke Laird</u>		

(Licensed Embalmer's Statement on Reverse Side)

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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 RO. Baird

Licensed Embalmer No. 4538

P. O. Address Jackson, 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.