

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12550
 12-14

1. PLACE OF DEATH

County Jackson Registration District No. 323
 Township Basin Primary Registration District No. 1102
 City K.C. Mo. (No. 1908 - East 36th) St. 13 Ward 1413

File No. 1413
 Registered No. 1413

2. FULL NAME

William H. Wells
 (a) Residence. No. 1908 East - 36 St. 13 Ward 1413
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Daisy Wells</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug - 26 - 1878</u>		
7. AGE	YEARS <u>51</u>	MONTHS <u>7</u>
	YEARS <u>6</u>	IT LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Packer</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Jamestown
 (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER <u>Alvander Wells</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>
	12. MAIDEN NAME OF MOTHER <u>No Record</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>

14. INFORMANT Daisy Wells
 (Address) 1908 - E. 36th St.

15. FILED 4/3 20 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 2 1930
 17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner
 19....., to 19....., 19.....
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 8:30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asst. 99 B

CONTRIBUTORY (SECONDARY)

9102

18. WHERE WAS DISEASE CONTRACTED

0 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Crowe, M. D.

4/2 19 30 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial Park DATE OF BURIAL Apr - 5 1930

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

