

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

Do not use this space.

12842

1. PLACE OF DEATH

County Jackson Registration District No. 329
Township Law Primary Registration District No. 11092
City K. C. Mo. (No. Research Hosp)

File No. _____
Registered No. 1111
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1908 E 36th St. 13 Ward.

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 23 - 1910

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
19 3 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Helper Telephone Co.
(b) General nature of industry, business, or establishment in which employed (or employer) 108 700
(c) Name of employer

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

10. NAME OF FATHER Horner Wells

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Fairy Vandyghe

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. Fairy Wells
(Address) 1908 E. 36th St. K. C. Mo.

15. FILED 4/22 1930 M. M. Crowe REGISTRAR
Assn.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1930

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 22, 1930 that I last saw him alive on April 21, 1930, and that death occurred, on the date stated above, at 120 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Double lobar pneumonia, involving both lower lobes and right upper lobe.
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) acute fibrinous pericarditis
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Mo.

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS Blood culture, sputum, autopsy
(Signed) Paul H. Humphill M. D.
4/22 1930 (Address) 702 Argyle Bldg.

*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 23 1930

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

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.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

702 Angyle Vi. 1311