OCT 31 1930

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

Do not use this space.

30664

File No.
Registered No.

1. PLACE OF DEATH
County: Oregon
Registration District No.: 632
Township:
Primary Registration District No.: 4382
City: Thayer (No. St. Ward)

2. FULL NAME: Clyde Wells

(a) Residence. No. St., 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: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 6 1921

7. AGE: Years 9 Months 2 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Howell Co.
(STATE OR COUNTRY): ~~Oregon Co.~~

PARENTS
10. NAME OF FATHER: Lewis Wells
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Fulton Co. Ark.
12. MAIDEN NAME OF MOTHER: Trissie Tonsby
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo.

14. INFORMANT: A. L. Corn
(Address): Meyer. Mo.

15. FILED Sep. 26 1930 C. Rhea REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sep. 21 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1930, to Sept. 20, 1930, that I last saw him alive on Sept. 20, 1930, and that death occurred, on the date stated above, at 6:00 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Tubercular
Infection
IVSH
3YC (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
Sep. 26 1930 (Signed) H. Mann, M. D.
(Address) Mammoth Sp. Ark.

*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: Thayer Mo.
DATE OF BURIAL: 9-25 1930

20. UNDERTAKER: Leo Carr
ADDRESS: Thayer Mo.

Be carefully supplied. ... plain (ceral, so that it may be properly classified. Exact statement of OCCUPATION is very important.
CAUSE OF DEATH ... PHYSICIANS should state ... ACTLY.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Oregon — Registration District No. 632 — File No. .....

Township ..... — Primary Registration District No. 4382 — Registered No. .....

City Thayer (No. ..... St. ..... Ward)

2. FULL NAME Clyde Wells

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED Sept 26, 1930 C. Rhea
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 21 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular Infection of body.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

3/13

N. B.— Every item of information sho... AGE should be stated ... EXACTLY. PHYSICIAN ... CAUSE ... that it may be properly classified. Exact statement of OCCUPATION ... REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-30664