

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

Do not use this space.

31614
287

1. PLACE OF DEATH

County St. Louis Registration District No. 411 File No. 287
 Township St. Louis Primary Registration District No. 2002 Registered No.
 City St. Louis (No.) St. Ward

2. FULL NAME

(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 <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widow</u>
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Heston Wells</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 15 - 1874</u>		
7. AGE <u>84</u>	YEARS	MONTHS <u>8</u>
		DAYS <u>4</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>retired</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>house wife</u>		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19 1931
 22. I HEREBY CERTIFY That I attended deceased from Sept 10 1931 to Sept 17 1931
 I last saw her alive on Sept 17 1931. Death is said to have occurred on the date stated above, at St. Louis.

The principal cause of death and related causes of importance were as follows:

Paralysis

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Barry Co</u>
13. NAME <u>James W. Connelley</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis</u>
15. MAIDEN NAME <u>Debra Connelley</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis</u>
17. INFORMANT (ADDRESS) <u>Frank H. Hughes</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Graves No. 9-21-37</u>
19. UNDERTAKER (ADDRESS) <u>W. B. Chapman</u>
20. FILED <u>Sept 21 1931</u> Registrar <u>W. B. Chapman</u>

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury , 1931
 Where did injury occur?
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) W. B. Chapman, M. D.
 (Address) St. Louis 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.

OCT 23 1931

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper Registration District No. 411 File No. _____
 Township _____ Primary Registration District No. 2012 Registered No. 287
 City Joplin (No. _____) St. _____ Ward _____

2. FULL NAME

Margaret Abigail 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/19 19 31

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

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, IB____, that I last saw h. _____ alive on _____, 1B____, and that death occurred, on the date stated above, at _____, Mo.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Septicemia
Bulbar
 (duration) yrs. mos. ds.

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 _____

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

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

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.

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) _____

INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

ED. 11/4 1931 H. Benson Clark
 REGISTRAR

SUPPLEMENTARY

STATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Statement of OCCUPATION is very important.

S-31611