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

Do not use this space.

4402

1. PLACE OF DEATH

County Greene — Registration District No. 944 — File No. 44

Township Jackson — Primary Registration District No. 54476 — Registered No. 44

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

2. FULL NAME Ettie Isabella 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.

39

MAR 22 1932

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 26-1868

7. AGE: 63 YEARS — MONTHS: 8 — DAYS: 3 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Wm C. Osborn

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

12. MAIDEN NAME OF MOTHER Susan J. Kepley

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

14. INFORMANT Zacariah Wells (Address) Stratford Mo

15. FILED 3-1, 1932 A. B. Grier REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 29 1932

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 – 1931, to Feb 28, 1932 that I last saw her alive on Feb 28, 1932 and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

25A (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) [signature] (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH ..... (1)

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) R. H. Foch, M. D.

2/29, 1932 (Address) Stratford Mo

*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: Mt. Pisgah — DATE OF BURIAL: Mar 2 1932

20. UNDERTAKER: L. B. Jones, Buffalo Mo — ADDRESS

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.