

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

Do not use this space.

20187

1937

1. PLACE OF DEATH
 County: Henry Registration District No. 347
 Township: White Oak Primary Registration District No. 5495
 City: Waver Mo. No. _____ St. _____ Ward _____

2. FULL NAME Rebecka 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 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR, OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 10 - 1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>80</u>	<u>6</u>	<u>27</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) April 1937 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

FATHER

13. NAME Jonathan Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

MOTHER

15. MAIDEN NAME Sarah Ann Gump

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT Anna Wells
 (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Waver Cemetery DATE May 8, 1937

19. UNDERTAKER Smith & Graham
 (ADDRESS) Waver Mo

20. FILED May 10, 1937 J. R. Hamblen
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 7, 1937

22. I HEREBY CERTIFY, That I attended deceased from May 5, 1937 to May 7, 1937.
 I last saw her alive on May 6, 1937. Death is said to have occurred on the date stated above, at 190A m.
 The principal cause of death and related causes of importance were as follows:

<u>Cerebral Hemorrhage</u>	Date of onset
Other contributory causes of importance: <u>none</u>	

Name of operation none 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 _____, 19____
 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? no
 If so, specify _____
 (Signed) S. H. Smith, M. D.
 (Address) Waver Mo

