

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.

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

Do not use this space.

OCT 19 1937

1. PLACE OF DEATH

County Jackson  
Township Ken  
City K. City (No. 1118 6 87)

Registration District No. 399  
Primary Registration District No. 1602

File No. 33266  
Registered No. 33266  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Walter Wells

(a) Residence, No. 500 East 8 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 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) Oct 27 - 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
31 10 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Hotel Work  
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) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milwaukee Wis

MOTHER FATHER 13. NAME John Wells

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milwaukee Wis

15. MAIDEN NAME Clare Schuder

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polina Wis

17. INFORMANT Valentine Wells (ADDRESS) Milwaukee Wis

18. ~~CREMATION~~ CREMATION, OR ~~INTERMENT~~ INTERMENT PLACE DATE 9/11 19

19. UNDERTAKER A Sebete (ADDRESS) 901 East 6th St

20. FILED Sept 12 1937 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/10/37 19

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19

I last saw him alive on \_\_\_\_\_, 19. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Gunshot wound of the head

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Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of operation \_\_\_\_\_  
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide. Date of injury 9/10/37  
Where did injury occur? 115 East 10th (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury Home by firearms  
Nature of injury \_\_\_\_\_

24. Was disease of which he died related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) W. Wells M. D.  
(Address) \_\_\_\_\_

