

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

18649  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County..... GREENE Registration District No. 316  
 (b) Township..... SPRINGFIELD Primary Registration District No. 2001 Registered No. 421  
 or  
 (c) City..... SPRINGFIELD (d) Street No. Springfield Baptist Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME CHARLIE WELLS  
 (a) Residence, No. \_\_\_\_\_ St.  Green Forest, Ark.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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 Clara Wells

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18 1900

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<input checked="" type="checkbox"/>	<u>38</u>	<u>11</u>	<u>4</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. Own farm  
 10. Date deceased last worked at this occupation (month and year) 5/13/39 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Forest, Arkansas

FATHER  
 13. NAME Jim Wells  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

MOTHER  
 15. MAIDEN NAME Dona Robertson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denver, Arkansas

17. INFORMANT (ADDRESS) Clara Wells, (wife)  
Green Forest, Ark.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Forest, Ark. DATE 5-29-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rea Nelson  
Berryville, Ark. 296

20. FILED 5-22-1939 Chas A. George MD  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/22/1939

22. I HEREBY CERTIFY, That I attended deceased from 5/16/1939, to 5/22/1939. I last saw him alive on 5/22/1939. Death is said to have occurred on the date stated above, at 7:45 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebro-spinal Meningitis (Pneumococcus) Date of onset 5/13/39  
na  
 Other contributory causes of importance: Pneumococcal pneumo- 5/11/39  
monitis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Spinal tap. Was there an autopsy? No

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) Herward G. Hall M. D.  
 (Address) 500 Halland Bldg. Springfield, 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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

X