

DEC 15 1939

Chapman

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

40448
Do not use this space.

1. PLACE OF DEATH

(a) County Demarcat 2 Registration District No. 833
(b) Township 1 Primary Registration District No. 4892 Registered No. _____
(c) City Steele (d) Street No. _____ 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

Helen Nannie Wells
(a) Residence, No. Steele Rt 2 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED unwed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 14 1905
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
34 6 5

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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) mo

FATHER
13. NAME Charles Wells

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

MOTHER
15. MAIDEN NAME Nannie Dallingham

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

17. INFORMANT (ADDRESS) James Wells
Steele mo Rt 2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Steele mo DATE 9-19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Holt Funeral Home
Belleville mo

20. FILED 13-1 1939 W. O. Chapman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 18 1939, to Sept 17 1939
I last saw her alive on Sept 18 1939 Death is said to have occurred on the date stated above, at 4:30 a.m.

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

infection after delivery Date of onset _____

Other contributory causes of importance: 1 W

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 _____ 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?
If so, specify _____
(Signed) W. O. Chapman M. D.
Address Steele, 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.

RECEIVED

District Health Officer No. 3,

District File Number 1239-6

Date Filed 12/8/39

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.