

FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

6698

144

Registration District No. 318

Primary Registration District No. 5439

Registrar's No.

39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: O. Alma House 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME JOSEPH D. WELLS 420

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 28 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Lehnd Cabinet Maper

11. Industry or business Cabinet Shop

12. Name James Wells

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Eddie H. Wells

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Feb 13 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. Kingman

18. (a) Signature of funeral director _____ (b) Address _____

19. 2-13-40 (Date received by Registrar) Chas A Renge n. 0 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits write "RURAL")
(d) Street No. R# 11
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1940 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to Feb 11 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 1 Mo
Chronic Hepatitis 1 yr.
Due to Ashtma 121 10 yrs.

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____ Of operations _____ Of autopsy _____ PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
Signature E. C. Mullins M. D. or other MD
Address Springfield, Mo. Date signed 2/17/40

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.....

Edo Lane Jr.

Registered Apprentice No. *232*

working under my personal supervision.

Signed *Clement D. Noble*

Licensed Embalmer No. *4005*

P. O. Address *Springfield*

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