

Registration District No. 625 Primary Registration District No. 5827

1. PLACE OF DEATH:  
(a) County Nodaway  
(b) City or town Maryville  
(c) Name of hospital or institution: 4 mi west 4 South  
(d) Length of stay: In hospital or institution 35 yrs.  
In this community 35 yrs.

3. (a) PRINT FULL NAME WILLIAM ROBERT WELLS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex m. 5. Color or race W  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Myrtle Esther Wells  
6. (c) Age of husband or wife if alive 28 years (Year) 1870

7. Birth date of deceased Aug (Month) 28 (Day) 1870 (Year)  
8. AGE: Years 69 Months 11 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Ontario (City, town, or county) Canada (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Chas. Wells  
13. Birthplace Ontario (City, town, or county) Canada (State or foreign country)  
14. Maiden name Mary Thompson  
15. Birthplace Ireland (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Mrs. Roger Miller  
(b) Address Salina Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director John W. Prick  
(b) Address Maryville Mo

19. (a) Aug 23 (Date received local registrar) (b) Norman E. Clardy (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Nodaway  
(c) City or town Maryville  
(d) Street No. 8 Miles S. West  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug. day 19 year 1940 hour 11 minute 45 a. M.  
21. I hereby certify that I attended the deceased from June 16 1940 to Aug 19 1940  
that I last saw him alive on Aug 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis  
Pernicious Anemia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 92 W  
(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? 556 (Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J G Manning (M. D. or \_\_\_\_\_)  
Address Skidmore Mo Date signed 8/21/40

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

RECEIVED  
District Health Officer No. 11,  
District File Number 940-1876  
Date Filed SEP 11 1940

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

*John W. Price*

Licensed Embalmer No. 3229

P. O. Address

*Maryville Mo.*

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.