

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **43451**  
Registrar's No. **389**

Registration District No. **668**

Primary Registration District No. **3032**

1. PLACE OF DEATH

(a) County **Pettis**  
(b) City or town **Sedalia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Bothwell Memorial Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 weeks**  
(Specify whether  
In this community years, months or days) **1**

8. (a) PRINT FULL NAME **Mrs. Mary Gladys Wells**

8. (b) If veteran, name war **none** 8. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Arley Wells** 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **June 13, 1891**  
(Month) (Day) (Year)

8. AGE: Years **49** Months **5** Days **14** If less than one day hr. min.

9. Birthplace **Todds Point, Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **E.H. Herrick**  
13. Birthplace **Canton, Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Tamar Oversby**  
15. Birthplace **Decatur, Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Arley Wells**  
(b) Address **Green Ridge, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 30 '40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Ridge Cemetery**

18. (a) Signature of funeral director **Phane Ewing**  
(b) Address **Sedalia, Missouri**

19. (a) **12/10/40** (b) **Mrs. Harry Reed**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pettis**  
(c) City or town **Green Ridge (Rural)**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **0** (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11-27** day **27**  
year **40** hour **8** minute **0** M.

21. I hereby certify that I attended the deceased from **11-9**, 19**40**, to **11-27**, 19**40**  
that I last saw her alive on **11-27**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Decompensated heart** Duration **1 yr**

Due to **Myocardial regurgitant**

Due to **21**

Other conditions **Chronic appendicitis**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **large uterine fibroid tumor**

Of autopsy

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?

**906**  
(Specify type of place) While at work? (e) Means of injury

23. Signature **Dr. Eyer** (M. D. or other)  
Address **Sedalia Mo** Date signed **11/27/40**

*As Dyer*

RECEIVED  
District Health Officer No. 8,  
District File Number  
1-14-41  
Date Filed

**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 *Arvane Ewing*  
Licensed Embalmer No. *3847*  
P. O. Address *Sedalia, Miss*

**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.