

FEB 14 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21447

Registration District No. 139

Primary Registration District No. 5199

Registrar's No. 1

1. PLACE OF DEATH:  
(a) County Carroll  
(b) City or town Tina, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution All his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Chauncey C. Wells  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 3 divorced  
6. (b) Name of husband or wife Anna A. Wells 6. (c) Age of husband or wife if alive ? years  
7. Birth date of deceased June 14 - 1867 (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 20 If less than one day hr. min.

9. Birthplace Hale, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

MOTHER, FATHER { 12. Name Benjamin Wells  
13. Birthplace Ill. (City, town, or county) (State or foreign country)  
14. Maiden name Mary Ramsey  
15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Hugh F. Wells  
(b) Address Hale, Missouri, RFD

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/1941 (Month) (Day) (Year)  
(c) Place: burial or cremation Avalon

18. (a) Signature of funeral director Clifford W. Austin  
(b) Address Tina, Missouri

19. (a) Jan 6 1941 (Date received local registrar) (b) Mrs R. A. Henderson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Carroll  
(c) City or town Tina, Missouri (If outside city or town limits, write "RURAL")  
(d) Street No. RFD (If rural, give location)  
(e) If foreign born, how long in U. S. A. All his life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4 year 1941 hour 7:30 PM M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Fractures of neck  
due to automobile accident  
on Highway 65 - 14 miles  
north of Carrollton, Mo  
Other conditions (include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

Duration  
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) Accident  
(b) Date of occurrence Jan. 4, 1941  
(c) Where did injury occur? Tina, Carroll, Mo (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
271 Highway 65  
While at work? No (Specify type of place) (e) Means of injury Automobile  
23. Signature D. E. Smith, Coroner (M. D. or other)  
Address Tina, Mo. Date signed 1/5/41

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

170-C  
98

RECEIVED  
District Health Officer No. 8,  
District File Number 170-C-2  
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.....

*Clifford W Austin*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Clifford W Austin*

Licensed Embalmer No. 3233

P. O. Address Teno Missouri

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2144

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 139

Primary Registration District No. 5199

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Carrroll  
(b) City or town State Grand Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Chauncey C. Wells

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 4 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death fracture of neck due to auto. accident on Hwy 65 - 14 miles north of Carrollton

Duration Accident was physician on highway 65, walking south. Auto came up behind him. Physician was not seen by driver, due to car lights approaching from south.

Other conditions (Include operations within 3 months of death) \_\_\_\_\_  
Main findings: \_\_\_\_\_  
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) acc

(b) Date of occurrence Jan 4 1941

(c) Where did injury occur? hwy (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hwy 65

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury auto

23. Signature E. L. Smith, M.D. (M. D. or other) DO  
Address Tina, Mo. Date signed 4/2/41

SUPPLEMENTARY

