

No. 2
1-1-0

FILED APR 1 1942

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1111

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town KC Mo
(c) Name of hospital or institution
Hunt Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 52 Days
(Specify whether
In this community 8 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town KC Mo
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. 624 Cottage Lane
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME

JAMES WELLS

3. (b) If veteran, name war No
3. (c) Social Security No. 487723087

4. Sex m
5. Color or race negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Carrie Wells
6. (c) Age of husband or wife if known years
7. Birth date of deceased 1000 25 1887
(Month) (Day) (Year)

8. AGE: Years 54 58 Months 2 20 Days
If less than one day hr. min.

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

10. Usual occupation Common laborer

11. Industry or business W.P.A.

12. Name Don't know

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie Wells (widow)

(b) Address 624 Cottage Lane

17. (a) Burial (b) Date thereof 3-18-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lave

18. (a) Signature of medical director
(b) Address 01819 E. 65th KC Mo

19. (a) 3-18-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month day 3.15.42
7 year minute M.

21. I hereby certify that I attended the deceased from 11:05 a.m.
that he/she was alive on 19...
and that death occurred on the date and hour stated above.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 3.15.42
7 year minute M.

21. I hereby certify that I attended the deceased from 11:05 a.m.
that he/she was alive on 19...
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute mediastinitis
Due to Refraction of esophagus

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external cause, 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) (c) Means of injury

23. Signature M. M. Crowe (M. D. or other)

Address K.C. Mo. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48
3
8

361

[Handwritten scribbles]

[Handwritten scribbles]

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 *[Signature]*

Licensed Embalmer No. *3836*

P. O. Address *8196 15th Newbury*

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, fact should be so stated above.

Registration District No. **399**

Primary Registration District No. **1082**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(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
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME

James Wells

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

4. Sex **m** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Dec 25 1888**
(Month) (Day) (Year)

8. AGE: Years **54** Months **2** Days **10** If less than one day min.

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

10. Usual occupation
11. Industry of business

MOTHER FATHER
12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

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

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

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

19. (a) **10/10/1947** (b) **M. H. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **mar** day **9** year **1942** hour..... minute..... M.
21. I hereby certify that attended the deceased from..... 19.....
that I have seen him/her alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Dissection of esophagus
Due to.....
due to phagodynamic ulcer
Due to.....
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.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

