

V. S. No. 2
OM-9-4-41
Rev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

13172

State File No.

FILED MAY 7 1942 791

Registration District No. Primary Registration District No. Registrar's No. 3601

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town, St. Louis
(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 2 days
(Specify whether years, months or days)

In this community 40 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 29 Lenox Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME George E. Wells

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eloise G. Wells

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased April 29, 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	11	23hr.min.

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

10. Usual occupation Consulting Engineer

11. Industry or business.....

12. Name Benjamin Wells

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

14. Maiden name Rose Cornell

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

16. (a) Informant David G. Wells

(b) Address 29 Lenox Place

17. (a) cremation (b) Date thereof 4/23/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mo. Crematory

18. (a) Signature of funeral director Wagoner Und. Co.

(b) Address 3621 Olive St.

19. (a) ADD 22 1042 (b) J. F. Bruback
(Date when last recorded) (Registrar's signature) XUV

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4/22/42 day 22 year 1942 hour 10:00 minute 10 M.

21. I hereby certify that I attended the deceased from 4/22/42 to 4/22/42
that I last saw him alive on 10/22/42 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Intestinal obstruction</u>	<u>1 day</u>
Due to <u>adhesion</u>	
<u>myocardial degeneration</u>	<u>(3)</u>
Due to <u>arteriosclerosis</u>	
Other conditions <u>bronchial pneumonia</u>	<u>1 day</u>
Major findings: Of operations <u>as above</u>	PHYSICIAN
Of autopsy <u>as above</u>	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) no

(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?
(Specify type of place)

While at work?..... (e) Means of injury car

23. Signature OD Fall (M. D. or other) yes

Address North 1st Kelly Date signed 4/22/42

103E
Dr. O. P. J. Falk
3604 Washington Ave.

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 Neville B. Frohwitter

Licensed Embalmer No. 3696

P. O. Address 3621 Olivest

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.