

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 8 1943

Registration District No. 2

Primary Registration District No. 4009

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Osborn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Kish's Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days
(Specify whether years, months or days)

In this community 26 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 18

(c) City or town Osborn
(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. 21 years

8. (a) PRINT FULL NAME George Henry Wells

8. (b) If veteran, name war Ind.

8. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 18
year 1943 hour 9 minute 45 A.M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Marie Wells

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 4-18-1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-27-1942 to 4-18-1943
that I last saw him alive on 4-18-1943
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>9</u>	<u>0</u>	hr. _____ min. _____

Immediate cause of death Carcinoma left side chest

Due to Primary seat chest

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

Other conditions 53
(Include pregnancy within 3 months of death)

10. Usual occupation Electrician

11. Industry or business _____

MOTHER FATHER

12. Name Marian Wells

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

14. Maiden name Martha Sulvan

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs. Marian Wells

(b) Address Osborn Kans.

17. (a) Removal (b) Date thereof 4-19-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osborn Kansas

18. (a) Signature of funeral director Hatter Meierhoffer

(b) Address St. Joseph, Mo.

19. (a) 4-20-43 (b) J. B. Fitchman
(Date received local registrar) (Registrar's signature)

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 Willard G. Stearns (M. D. or other) _____

Address Osborn, Mo. Date signed 4-18-43

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 1-1-41 1 X10811

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..... *Geo. E. Daniel*

Licensed Embalmer No..... *3300 Missouri*

P. O. Address..... *St. Joseph, 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.