

ED AUG 6 1943/49
Registration District No.

Primary Registration District No. 1002

3104

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Conley Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 423 Cambridge
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13
year 1943 hour 10 minute 35 P. M.

4. Sex Male

5. Color or race W

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

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

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

7. Birth date of deceased July 10, 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 5, 1943 to July 13, 1943
that I last saw him alive on July 13, 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>0</u>	<u>3</u>	hr. _____ min.

Immediate cause of death _____

Heart failure

Due to Chronic myocarditis

Due to Chronic myocarditis

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

Other conditions (include pregnancy within 3 months of death) 93d

10. Usual occupation Merchant

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business Self

MOTHER FATHER

12. Name W. T. Wells

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name No Record
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Orville Jasper

(b) Address 419 Cambridge, K.C. Mo.

17. (a) Burial (b) Date thereof July 15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 66 6606 Indep. Ave. K.C. Mo.

19. (a) 7-14-43 (b) W. E. Brown
(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 W. E. Brown (Date signed) 6-14-43

Address 619 Garfield, Council Bluffs, Mo.

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

Dr. Anderson

Conley Clinto

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:.....

Licensed Embalmer No.....

P. O. Address.....

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: