S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31074

State File No.

FILED OCT 11 1943

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 237

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 months (Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan 105

(c) City or town Pollock Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson Twp.
(If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME Thomas Nelson Wells

3. (b) If veteran, name war Mo

3. (c) Social Security No. Mo.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Verda May Wells

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

7. Birth date of deceased August (Month) 22 (Day) 1875 (Year)

8. AGE: Years 68 Months 0 Days 14 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Charles Wells
13. Birthplace (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Martha McCormick
15. Birthplace (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Minnie Wells
(b) Address Pollock, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 (Month) 1943 (Day) (Year)
(c) Place: burial or cremation Campbell Cem, Pollock

18. (a) Signature of funeral director Schoene's
(b) Address Milan, Mo. Frank D.

19. (a) 9/9/43 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day Sixth year 1943 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from March 15, 1943 to Sept. 6, 1943 that I last saw him alive on Sept. 6, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Acute Myocardial Failure

Due to Chronic Myocarditis

Other conditions None.
(Include pregnancy within 3 months of death)

93d

Major findings:
Of operations No Operations

Of autopsy No 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)

(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

23. Signature A. R. Schultz (Mo. other) DD

Address 503 E Benton Kirksville, Mo. Date signed 9/6/43

1044

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-43-1654
Date Filed OCT 7 1949

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 Frank D. Schoen

Licensed Embalmer No. 2916

P. O. Address Milan, Mo.

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.