

FILED FEB 19 1944

Registration District No. 191

Primary Registration District No. 4-304

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town Ludlow (Monroe twm.)
(If outside city or town limits, write "RURAL" and name of township)
 (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 64yrs
(Specify whether years, months or days)
 In this community 64yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
 (c) City or town Ludlow (Monroe Twn)
(If outside city or town limits, write "RURAL")
 (d) Street No. Rural
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th
 year 1944 hour 9 minute 00a.m.
 21. I hereby certify that I attended the deceased from March 18th
 to Jan 17 1944
 that I last saw her alive on January 17 1944
 and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Sarah Elizabeth Wells

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

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow

(b) Name of husband or wife Alonzo Wells 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Oct. 25th, 1856
(Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days 24 If less than one day
hr. min.

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

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER { 12. Name Silas Smith
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Selina M. Smith
 15. Birthplace Ludlow Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Wells
 (b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 1-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)
McCroskey Cem.
 (c) Place: burial or cremation

18. (a) Signature of funeral director Bernard J. Mead
 (b) Address Braymer, Missouri

19. (a) 1-25-44 (b) Hannel Capple
(Date received local registrar) (Registrar's signature)

Immediate cause of death Carcinoma of uterus
 Due to 4yrs

Due to H&B
 Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
 Of autopsy ---

Duration 4yrs
 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 H. A. Quincy (M. D. or other) ---
 Address Ludlow, Mo. Date signed 1/19/44

1004

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

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.

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Signed *Bernard J. Neal*

Licensed Embalmer No. *2801*

P. O. Address *Dayton*

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. 191 Primary Registration District No. 5-7051

MAR

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution: Monroe Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

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

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

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: Oct 25
(Month) (Day) (Year)

8. AGE: Years 87 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) 125/1914 (b) Hanna Capple
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 16 Year 1944 hour _____ minute 9 M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

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 Dr. J. C. Ketchum (M. D. or other) D.O.
Address Lindlow Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

100

7685