

FILED SEP 5 1944

Registrar's No. 864

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: Mo. Meth Hosp
(d) Length of stay: In hospital or institution 10 da
In this community 33 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(d) Street No. 633 Albemarle
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Zeta N. 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 Married
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive years 41
7. Birth date of deceased Mar 4 1898

8. AGE: Years 46 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Watson Mo. O

10. Usual occupation Housewife

11. Industry or business _____

12. Name Walter Chostain
13. Birthplace unknown
14. Maiden name Spicie Ellen
15. Birthplace unknown

16. (a) Informant Goo. Wells (b) Address St Joseph, Mo

17. (a) Burial (b) Date thereof 8-30-44
(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Floeman & son Inc
(b) Address St Joseph, Mo

19. (a) 8/30/44 (b) Helen J. Pickle
(c) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1944 hour 2 minute 30 A.M.
21. I hereby certify that I attended the deceased from June 30-44 to Aug 27, 1944
that I last saw him alive on Aug 27, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis
Duration 2 hrs.

Due to Aneurysm Fibillation 17 da

Other conditions (Include pregnancy within 5 months of death) 94a

Major findings: Of operations _____ Of autopsy none
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) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? no (Specify type of place) (c) Means of injury 40

23. Signature H. D. Kearly M.D. (M. D. or other) Address St Joseph Mo Date signed 8-28-44

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.

Signed

Robert D. Viper

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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.