

S. No. 2  
M-2-43  
5-17-39  
P-I X35637

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37821

State File No. \_\_\_\_\_

FILED DEC 7 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 933

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution Springfield Baptist Hospital  
(d) Length of stay: In hospital or institution 19 days  
In this community 19 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone  
(c) City or town Galena  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Harvey Wells

3. (b) If veteran, name war no 3. (c) Social Security No. 500-05-2030

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Mina Wells 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Oct. 12, 1875

8. AGE: Years 69 Months 0 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Laurens Co. Mo.

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James W. Wells  
13. Birthplace Tex. Ark.  
14. Maiden name Let Ann Hamman  
15. Birthplace unk. Kansas

16. (a) Informant Raymond Wells  
(b) Address Galena, Mo.

17. (a) burial (b) Date thereof Oct. 29-44

(c) Place: burial or cremation Galena Cemetery

18. (a) Signature of funeral director Wesley S. Cheatham

(b) Address Galena, Mo.  
19. (a) 11-22-44 (b) W. H. Handley

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27 year 1944 hour 3 minute 15 a. M.

21. I hereby certify that I attended the deceased from Oct 6, 1944 to Oct 27, 1944  
that I last saw him alive on Oct 26, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Transverse myelitis  
Due to Urinary septicemia  
Due to Hypostatic bronchopneumonia  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration  
5 mo  
1 mo  
3 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations 82!!  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature Robert S. ... (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 10/35

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 *Everett J. Cheatham*

Licensed Embalmer No. *3878*

P. O. Address *Salina, 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.**