

FILED FEB 8 1945  
Registration District No. 93

Primary Registration District No. 4154

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Dade  
(b) City or town GREENFIELD  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
MILLIPAN REST HOME 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution TWO WEEKS  
(Specify whether  
In this community 17 YRS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dade 27  
(c) City or town GREENFIELD 1  
(If outside city or town limits, write "RURAL.") 0  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME ROBERT C. WELLS

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced. 2  
6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive. years  
7. Birth date of deceased 3 4 1853  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 8 26 hr. min.

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

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER

12. Name UNKNOWN  
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant LEE WELLS  
(b) Address ASH GROVE MO

17. (a) BURIAL (b) Date thereof 12 31 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation ASH GROVE MO

18. (a) Signature of funeral director W. J. RYAN & LEIMAN  
(b) Address ASH GROVE

19. (a) 1/1/45 (b) Phyllis Lack  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29  
year 1944 hour 11:15 minute P M.  
21. I hereby certify that I attended the deceased from 12-29-44  
19 to 12-29 19 44  
that I last saw him alive on 12-29 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Due to Senility  
Duration

Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: 94a  
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) (Specify means of injury)  
23. Signature Wesley H. Buckner, D.O.  
Address Greenfield Mo Date signed 1-2-45

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

9  
1  
0

RECEIVED

District Health Officer No. 6;

District File Number 245-156

Date Filed FEB 6 1945

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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 Maude D. Morris

Licensed Embalmer No. 2066

P. O. Address Ash Grove

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.