

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: South East Missouri Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 hrs
In this community 20 hrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir
(c) City or town Jackson
(If outside city or town limits, write "RURAL")
(d) Street No. 1909 Addition
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12
year 1945 hour 5 minute A.M.
21. I hereby certify that I attended the deceased from Feb 7, 1945 to Feb 12, 1945
that I last saw him alive on Feb 11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial
Duration 10 days

3. (a) PRINT FULL NAME Jesse King Wells
3. (b) If veteran, name war _____
3. (c) Social Security No. 486-14-6088

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dinnie O Wells
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Feb 21 1886
(Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 21
If less than one day hr. min.

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

10. Usual occupation OFFICE CLERK

11. Industry or business _____

12. Name Elias Wells
13. Birthplace Barkley Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Sarah George
15. Birthplace Stoddard MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs J.K. Wells
(b) Address Jackson MO

17. (a) Burial (b) Date thereof FEB 15 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baker Cem

18. (a) Signature of funeral director Wilson & Stoddard
(b) Address Jackson MO

19. (a) 2-16-45 (b) J.K. Wells
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings:
Of operations None
Of autopsy _____

22. If death was due to external causes, fill in the following:

(c) 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 J.P. Dickman (M. D. or other) _____

Address Jackson MO 7920 Date signed 2-16-45

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

6
1
4

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 345-326

Date Filed 3-6-45

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.