

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10391

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1203 S. Osage!  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 yr (Specify whether years, months or days)  
In this community 6 yr

3. (a) PRINT FULL NAME

BERT WELLS

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Frances Melton Wells

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Dec 8 - 1875 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

69

2

27

hr.

min.

9. Birthplace

Cooper Co

mo

D

(City, town, or county)

(State or foreign country)

10. Usual occupation

Carpenter

11. Industry or business

Contractor

12. Name

Lee Anderson Wells

13. Birthplace

Ind. !

(City, town, or county)

(State or foreign country)

14. Maiden name

Eleanor Davis

15. Birthplace

Zainville

Ohio

(City, town, or county)

(State or foreign country)

16. (a) Informant

Mrs. Earl Kuhn

(b) Address

Arrow Rock mo

17. (a)

Burial

(b) Date thereof

3-7-45

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Pilot Grove mo

18. (a) Signature of funeral director

Harry Herschberger

(b) Address

Marshall mo

19. (a)

2-7-45

(b)

Mrs. Anna Berger

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Pettis  
(c) City or town Sedalia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1203 S Osage  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month

md

day

5

year

1945

hour

2

minute

A. M.

21. I hereby certify that I attended the deceased from

2-8

1945

to

3/5

1945

that I last saw him alive on

3-4

1945

and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma Stomach 2 yrs

Duration

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?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. W. Boyer

(M. D. or other)

Address

Sedalia Mo

Date signed

1022

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

DEC 28 1950

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

*Harry Hershberger*

Licensed Embalmer No.

*4357*

P. O. Address

*Marshall 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.