

FILED JUN 19 1945

Registration District No. **818** Primary Registration District No. **1003** Registrar's No. **5128**

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether

In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. 1618 Cole St.
(If rural, give location)

(e) Citizen of foreign country?.....
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Eugene Wells

3. (b) If veteran, name war.....

3. (c) Social Security No. 491-14-7619

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Thelma

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

7. Birth date of deceased April 6th 1891
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6,
year 1945 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from June 4, 1945, to June 6, 1945;
that I last saw him alive on June 6, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebro-vascular accident Duration 2 days

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>2</u>	<u>0</u>	hr. _____ min.

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy.....

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

10. Usual occupation Laborer

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

MOTHER FATHER

12. Name William Wells

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

14. Maiden name Nettie Reid

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

16. (a) Informant Dora Davis

(b) Address 4202a W. Belle

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

17. (a) Burial (b) Date thereof June 16, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

(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?.....

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) JUN 11 1945 (b) J. F. Busch
(Date received local registrar) (Registrar's signature)

While at work..... (Specify type of place) (e) Means of injury.....

23. Signature B. F. Murphy M. D. or other.....
Address 260 W. Belle Date signed 6/7/45

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

10
7
9

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.....

Thomas J. Gates, Registered Apprentice No.....
working under my personal supervision.

Signed.....
Thomas J. Gates

Licensed Embalmer No. *4259*

P.O. Address *4107 Finney Ave*

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.