

FILED AUG 24 1945 STANDARD CERTIFICATE OF DEATH

State File No. 28667

Registration District No. 333

Primary Registration District No. 3074

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Sikeston
(If outside city or town limits, write "RURAL")

(d) Street No. Sunset Addition
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME James Wells

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

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced S (1)

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

4 10 9 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Charley Wells

13. Birthplace Tupulo Miss. (City, town, or county) (State or foreign country)

14. Maiden name Laura Evans

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

16. (a) Informant Charley Wells

(b) Address Sikeston, Mo. R#1 Box 6

17. (a) Burial (b) Date thereof 6/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H.W. Albritton
(b) Address Sikeston, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31st
year 1945 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from 5-28-45 to 5-29-45, 1945.
that I last saw him alive on 5-29-45, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Secondary Anemia

Due to Splenomegaly

Due to _____

Duration
2 mos.
6 mos.

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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature W. A. Singal (M. D. or other) _____
Address 204 S. Locust St. Sikeston, Mo. signed 6-9-45

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

RECEIVED
District Health Office No. 2
District File Number 245-203
Date Filed 8-21-45

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.....

Embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed *John Allenton*

Licensed Embalmer No. 2941

P. O. Address *Shelton*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. SeptRegistration District No. 333Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Scott
 (b) City or town Sikeston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME

James Wells

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m5. Color or race B

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July 22

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/12/45

(Date received local registrar)

(b) Lois Largent

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

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

Immediate cause of death _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-28667