

S. No. 2
M-5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10350

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 91

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: Bothwell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 41 years

3. (a) PRINT FULL NAME William Thomas 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 Widowed
6. (b) Name of husband or wife Elizabeth Lamb Wells 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
76 10 3 hr. min.

9. Birthplace Bunker Hill Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation Retired Salesman

11. Industry or business

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 Miss Lura McCluney
(b) Address 614 W. 7th, Sedalia, Mo.

17. (a) Removal (b) Date thereof March 23, 1946 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery Fayetteville, Tenn.

18. (a) Signature of funeral director. McLaughlin Bros.
(b) Address Sedalia, Mo.

19. (a) 3-23-46 (b) Betty Yeager (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis
(c) City or town Sedalia (If outside city or town limits, write "RURAL")
(d) Street No. 614 West 7th (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 st year 1946 hour 10.15 minute P M.

21. I hereby certify that I attended the deceased from over 15 years - 19 to March 21 1946.
that I last saw him alive on March 21 1946.
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration Over 5 years

Due to Anemia

Due to

Other conditions Obv Prostatitis (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None 137

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

(a) Accident, suicide, or homicide (specify) none
(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) (c) Means of injury

23. Signature J. B. Carlier M.D. (M. D. or other) Address Sedalia Mo. Date signed 3-22-46

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

4-11-46

MAY 19 1951

JAN 6 1951

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.....

K. P. W. Crary

Licensed Embalmer No. 3153

P. O. Address Sedalia, 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.