S. No. 2
M—8-43
. 5-17-39
I X37823

16209

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 10 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17328

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 1

(c) City or town Macon 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Steven D Wells

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

3. (c) Social Security No. .....

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 9

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Sept (Month) 18 (Day) 1872 (Year)

8. AGE: Years 73 | Months 7 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Macon Co (City, town, or county) Mo 11 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name George Wells 9
13. Birthplace No Record 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Smith
15. Birthplace No Record 9 (City, town, or county) (State or foreign country)

16. (a) Informant Owen Wells
(b) Address Macon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10 46 (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood Cem

18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo

19. (a) May 31-46 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1946 hour 12:30 minute a M.

21. I hereby certify that I attended the deceased from Nov 1944 May 3 1946 to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Cardial Disease — Duration 1 yr or more

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 J. P. Gronoway (M.D. or other)

Address Macon Mo Date signed 5/16/46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-46-1129
Date Filed JUN 6 1946

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 Albert S Kimmel

Licensed Embalmer No. 75-1

P. O. Address Macon 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.