

No. 2
-12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16864**

Registration District No. **69**

Primary Registration District No. **6272**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **Christain**
(b) City or town **PORTER TWP rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Nixa Mo. Route #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 year** (Specify whether years, months or days)
In this community **1 year**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **39**
(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **430 E. Cherry** **6**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **John Wells**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Male** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **November 13 1877**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **12** year **1947** hour **1** minute **OOP.** M.
21. I hereby certify that I attended the deceased from **May 12** to **May 12**, 19**47**.
that I last saw him alive on **May 12**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure** Duration
Due to **Lobar Pneumonia**
Due to
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations **10**
Of autopsy

Underline the cause to which death should be charged statistically.

8. AGE: Years **64** Months **5** Days **29** If less than one day hr. min.

9. Birthplace **Bloomfield, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Poultry Dealer**

11. Industry or business **As Above**

12. Name **Abraham Wells**

13. Birthplace **Bloomfield, Iowa**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Ann Wells**

15. Birthplace **Bloomfield, Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lowell Inman**
(b) Address **Nixa Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-15-1947**
(Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park F&B Cem.**

18. (a) Signature of funeral director **J.W. Klingner & Co**
(b) Address **Springfield Mo.**
19. (a) **5-14-47** (Date received local registrar) (b) **Alvine Driver** (Registrar's signature) **10**

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 **2**
23. Signature **H. J. Newell** (M. D. or other) **H. J.**
Address **Nixa, Mo.** Date signed **5/14/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 647-639

Date Filed JUN 5 1947

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed *Max Rhodes*

Licensed Embalmer No. 4071

P. O. Address *Springfield*

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.