

## 1. PLACE OF DEATH:

(a) County Madison  
 (b) City or town Mexico, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Mexico General Hospital  
 (If not in hospital or institution, write street name or location)  
 (d) Length of stay: In hospital or institution 5 hrs (Specify whether  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Montgomery County, Missouri  
 (c) City or town Montgomery City, Mo  
 (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 \_\_\_\_\_

## 3. (a) PRINT FULL NAME

SALLY WELLMAN

## 3. (b) If veteran,

## 3. (c) Social Security No.

name war \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 0  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 8, 1948  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 hr. 15 min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name William J. Wellman13. Birthplace Detroit, Mich (City, town, or county) (State or foreign country)14. Maiden name Carola Hubbert15. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)16. (a) Informant William J. Wellman(b) Address Montgomery City, Mo17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August 8, 1948 (Month) (Day) (Year)(c) Place: burial or cremation Madison City Cemetery18. (a) Signature of funeral director William J. Wellman(b) Address Montgomery City, Mo19. (a) 8/14/48 (Date received local registrar) (b) Blanche Neely (Registrar's signature)20. DATE OF DEATH: Month August day 8year 1948 hour 10:15 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from birth  
Aug 8, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw her alive on Aug 8, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

Duration \_\_\_\_\_

Immediate cause of death asphyxia neonatorumDue to premature birthchild living 5 hr. 15 min.Due to spontaneous ruptureOther conditions member of family

(Include pregnancy within 3 months of death)

Major findings: an otherwise normal pregnancy

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 the place)

While at work? \_\_\_\_\_ (e) Class of injury \_\_\_\_\_

23. Signature William J. Wellman (M.D. or other) 159Address Montgomery City, Mo Date signed Aug 12-48

PHYSICIAN \_\_\_\_\_

Underline the cause of which death should be charged statistically.

RECEIVED

District Health Officer No.

District File Number 84817

Date Filed AUG 23 1948

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 116

1. PLACE OF DEATH:

(a) County Andrain  
(b) City or town Merces  
(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 Sally Wellman

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 8 (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 \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Montgomery  
(c) City or town Montgomery City  
(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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-25373