No. 2
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17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 8 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33535
State File No.

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 344

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Elizabeth Hop
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Marion 64
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 2009 Spruce
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Floyd Wells
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 2 | 5. Color or race Negro 1 | 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Beulah Wells
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 6 (Month) 4 (Day) 90 (Year)

8. AGE: Years 48 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Miami (City, town, or county) Mo (State or foreign country)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name John Wells
13. Birthplace Miami (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Rosie Oliver
15. Birthplace Palmyra (City, town, or county) Mo (State or foreign country)

16. (a) Informant Beulah Wells
(b) Address 2009 Spruce St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20 48 (Month) (Day) (Year)
(c) Place: burial or cremation Robinson Cem
18. (a) Signature of funeral director Geo. E. Roberts
(b) Address Hannibal
19. (a) 11-1-48 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1948 hour 12 minute 7 P.M.
21. I hereby certify that I attended the deceased from 9-20-48, 19..., to 10-17, 19 48 that I last saw him alive on 10-17-48, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism — Duration 1 day.
Due to Post Operative Gastric surgery — 3 days.
Due to Pylor duodenum — ?
Other conditions (Include pregnancy within 3 months of death) 17W
Major findings: Of operations Pylor duodenum. Obstruction duodenum
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 0

23. Signature W. L. Lucke (M. D. or other)
Address Holmes Bldg., Hannibal, Mo Date signed 10-25-48

(Licensed Embalmer's Statement on Reverse Side)

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 Geo E Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.