

FILED JUL 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22436

State File No.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3900 Registrar's No. 208

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>	
c. LENGTH OF STAY (In this place) <u>40 yr.</u>		d. STREET ADDRESS (If rural, give location) <u>308 E. Jefferson</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K.C.O.S. Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Laura</u>		b. (Middle) <u>Wells</u>	
c. (Last) <u>Wells</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>October 22, 1873</u>
9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u></u> Min. <u></u>	11. BIRTHPLACE (State or foreign country) <u>Sue City, Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Bert Stephens</u>		13b. MOTHER'S MAIDEN NAME <u>Judith Terrill</u>	
14. NAME OF HUSBAND OR WIFE <u>W. R. Wells</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Phradie Wells</u> ADDRESS <u>Turkville, Mo above</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>river failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Jaundice</u> DUE TO (c) <u>Carcinoma of Hepatic & common bile ducts</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diverticulosis of Sigmoid Colon</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>26 days</u> <u>unknown</u>		19. DATE OF OPERATION <u>6-15-49</u>	
19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of bile ducts at hilum of liver</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-13</u> , 19 <u>49</u> , to <u>6-26</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>49</u> , and that death occurred at <u>2:12 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>D. R. Spogler M.D.</u> (Degree or title)		23b. ADDRESS <u>Turkville Mo</u>	
23c. DATE SIGNED <u>6-27-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>6/28/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>	
24d. LOCATION (City, town, or county) (State) <u>Atlanta Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Davis Funeral Home, Kirkville, Mo</u> ADDRESS	
DATE REC'D BY LOCAL REG. <u>7-15-49</u>		REGISTRAR'S SIGNATURE <u>Hate Lambert</u>	

RECEIVED JUL 19 1949
District Health Officer No. 10
District File Number 7-49-1765
Date Filed JUL 19 1949

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, only

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No. _____

Signed

Clarence M. Bello

Licensed Embalmer No. 4375

P. O. Address

Kirksville, MD

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.