

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

FILED JUL 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24142**

BIRTH NO. _____ REG. DIST. NO. **217** PRIMARY REG. DIST. NO. **3045** Registrar's No. **61**

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE Missouri b. COUNTY Mississippi	
b. CITY OR TOWN Charleston		c. CITY OR TOWN Charleston	
d. FULL NAME OF HOSPITAL OR INSTITUTION 216 S. Locust St.		d. STREET ADDRESS (If rural, give location) 216 S. Locust St.	

3. NAME OF DECEASED (Type or Print) a. (First) Glase b. (Middle) Hunter c. (Last) Wells			4. DATE OF DEATH (Month) (Day) (Year) June 30, 1949		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 1889	9. AGE (In years last birthday) 59	if UNDER 1 YEAR Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Operator		10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) Newton, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Glase Wells	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Bettie Wells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Gaitha Wells
		ADDRESS 216 S. Locust, Charleston, Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days 4 years 744x
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____	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 **June 25, 1949** to **June 30, 1949**, that I last saw the deceased alive on **June 30, 1949** and that death occurred at **2:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Inscribed title) W. P. Fenton, D.D.	23b. ADDRESS Wyatt, Mo.	23c. DATE SIGNED 7-2-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 5, 1949	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery
DATE REC'D BY LOCAL REG. July 9-49		24d. LOCATION (City, town, or county) (State) Charleston, Missouri
REGISTRAR'S SIGNATURE Mrs. John Bondurant		25. FUNERAL DIRECTOR'S SIGNATURE F. J. Sparks
		ADDRESS Charleston, Mo.

RECEIVED

District Health Office No. 2

District File Number 749-72

Date Filed JUL 13 1946

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JUL 13 1946

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Frank J. Spaworth

Signed _____

Student Embalmer

Licensed Embalmer No. 3453

P. O. Address Agape Mendenhall

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.