

FILED OCT 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31143

State File No.

BIRTH NO. REG. DIST. NO. 233 PRIMARY REG. DIST. NO. 4348 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellsville</u>		c. LENGTH OF STAY (In this place) <u>28 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellsville</u>		70			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>306 Water Street</u>				d. STREET ADDRESS (If rural, give location) <u>306 Water Street</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>WHITTINGTON</u> b. (Middle) <u>-</u> c. (Last) <u>MAY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 5 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 5 1866</u>			
9. AGE (In years last birthday) <u>83</u>		10. MONTHS <u>0</u>		11. DAYS <u>0</u>		12. HOURS <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Daniel May</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Cohagen</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</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 ADDRESS <u>Mrs. Walter Hall, Wellsville</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>Carcinoma of Stomach</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 m.</u> <u>151X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min.)		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>Jan</u> 1949, to <u>Oct 6</u> , 1949, that I last saw the deceased alive on <u>Oct 6</u> , 1949, and that death occurred at <u>5:30 a. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>W. H. Wello M.D.</u>				23b. ADDRESS <u>W. H. Wello M.D. 10/7/49</u>		23c. DATE SIGNED <u>10/7/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/7/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Middletown, Montg. Mo</u>			
DATE REC'D BY LOCAL REG. <u>10/7/49</u>		REGISTRAR'S SIGNATURE <u>W. S. Roman</u>		FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Bell</u>		ADDRESS <u>Wellsville Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
OCT 11 1949
District Health Officer No. 9,
District File Number

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.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 1589

P. O. Address. *Walthamville, Me.*

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.