

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 9083  
844

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 35 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		3-208	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hosp				d. STREET ADDRESS (If rural, give location) 1116 Ewing			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Thomas		c. (Last) Wells	
4. DATE OF DEATH		(Month) 2		(Day) 21		(Year) 50	
5. SEX Male		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Div		8. DATE OF BIRTH 5/10/62	
9. AGE (in years last birthday) 87		IF UNDER 1 YEAR Months		IF UNDER 4 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Madison Co. Ind. /		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME John Wells		13b. MOTHER'S MAIDEN NAME Unk		14. NAME OF HUSBAND OR WIFE Mary E Steele			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Mrs Pearl Burnell		ADDRESS 1116 Ewing	
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) Hypostatic Pneumonia  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility Congestive heart failure 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 6 days  2 wks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4/3/11				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) m.		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 2/17/50 to 2/21, 1950, that I last saw the deceased alive on 2/21, 1950, and that death occurred at 6:44 P.M., from the causes and on the date stated above.							
23a. SIGNATURE Maurice M. Geraghty (Degree or title)				23b. ADDRESS 6045 Trueman Rd. K.C.		23c. DATE SIGNED 2/22/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) (1) 2/23/50		24b. DATE 2/23/50		24c. NAME OF CEMETERY OR CREMATORY Mt Washington		24d. LOCATION (City, town, or county) (State) Kansas City, MO.	
DATE REC'D BY LOCAL REG. 2-23-50		REGISTRAR'S SIGNATURE Geraldine Holmes		5. FUNERAL DIRECTOR'S SIGNATURE J. H. Kelley		ADDRESS R. C. Mo	

(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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed Charles E Mayfield

Signed.....  
Student Embalmer

Licensed Embalmer No. 4838

P. O. Address K.C. Mo.

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

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