

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35450

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8354

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5478 Alcott Ave		d. STREET ADDRESS (If rural, give location) 5478 Alcott Ave.	
3. NAME OF DECEASED a. (First) Amelia		b. (Middle)	
c. (Last) Wells		4. DATE OF DEATH (Month) (Day) (Year) 10 2 50	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH May 30th. 1866
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany 4
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Augustin Seitz	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE late John Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Alexander Wells		ADDRESS 5478 Alcott Ave	
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, asthemia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia INTERVAL BETWEEN ONSET AND DEATH 7 days ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Healed fracture right femur - 8 weeks Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	
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? 522X			
22. I hereby certify that I attended the deceased from Aug. 7, 1950, to Oct 2, 1950, that I last saw the deceased alive on Oct. 7, 1950, and that death occurred at 12:45 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R.R. Menowin, M.D.		23b. ADDRESS 5330 Geraldine Ave	
23c. DATE SIGNED 10-2-50.			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-5-1950	
24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis County Mo	
DATE REC'D BY LOCAL REG. OCT 4 1950		REGISTRAR'S SIGNATURE J. B. Swater	
25. FUNERAL DIRECTOR'S SIGNATURE Leidner U.		ADDRESS 2228 St. Louis Ave.	

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

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

J. W. Binkley

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, Mo*

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.