

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36625

FILED DEC 2 1950

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>163</u>				
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before of death.) a. STATE <u>Missouri</u> b. COUNTY <u>Warren</u>						
b. CITY OR TOWN <u>Washington</u>		c. LENGTH OF STAY (If this place) <u>3 da.</u>		c. CITY OR TOWN <u>Rural - Elkhorn</u>		1090				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>S. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Warrenton R.F.D.</u>						
3. NAME OF DECEASED (Type or Print) <u>ORNICE</u>			a. (First) <u>B.</u>		c. (Last) <u>WELLS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22, 1950</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 10, 1893</u>		9. AGE (In years if under 1 year, last birthday) <u>57</u>		10. MONTH <u>12</u>	11. DAY <u>22</u>	12. HOURS <u>12</u>	13. MIN. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Grant Boswell</u>			13b. MOTHER'S MAIDEN NAME <u>Cora Willingham</u>		14. NAME OF HUSBAND OR WIFE <u>James L. Wells</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>James L. Wells, Warrenton, Mo</u>		ADDRESS <u>Warrenton, Mo</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				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremic state</u>				DUPLICATE OF (a) <u>Uremic state</u>				2 day		
ANTECEDENT CAUSES As forid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE OF (b) <u>Cerebral embolism</u>				4 day		
DUPLICATE OF (c) <u>remittent</u>				DUPLICATE OF (c) <u>Chronic cholecystitis</u>				332.7 X cubic		
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) (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>Nov 9</u> , 19 <u>50</u> , to <u>Nov 22</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>11-22</u> , 19 <u>50</u> , and that death occurred at <u>9:33 A.M.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>H. Hoelscher, M.D.</u> (Degree or title)				23b. ADDRESS <u>Warrenton, Mo</u>			23c. DATE SIGNED <u>11-22-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 25, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Warrenton, Mo</u>				
DATE REC'D BY LOCAL REG. <u>Nov. 22, 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		990		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Nieburg & Son</u>		ADDRESS <u>Warrenton, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

NOV 25 1950

RECEIVED

DEC 2 1950

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 _____

Lester A. Pitt
3254

Licensed Embalmer No. _____

P. O. Address _____

Washington, 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.