

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 134

1. PLACE OF DEATH
 a. COUNTY BOONE
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN COLUMBIA
 c. LENGTH OF STAY (in this place) 31 DAYS
 d. FULL NAME OF HOSPITAL OR INSTITUTION ELLIS FISCHER STATE CANCER HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE MISSOURI b. COUNTY COOPER
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BLACKWATER 0270
 d. STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED
 a. (First) JOHN b. (Middle) MORTON c. (Last) SHEM WELL
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year) MAY 12 1951
 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1 8. DATE OF BIRTH MARCH 5, 1880 9. AGE (In years last birthday) 71 IF UNDER 1 YEAR: Months 2 Days 6 IF UNDER 4 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 10b. KIND OF BUSINESS OR INDUSTRY FARMING 11. BIRTHPLACE (State or foreign country) BLACKWATER, MISSOURI 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME WILLIAM D. SHEM WELL 13b. MOTHER'S MAIDEN NAME LUCY PLATT 14. NAME OF HUSBAND OR WIFE MAUDE SHEM WELL

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. UNKNOWN 17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORDS ADDRESS _____

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, ashenia, etc. It means the disease, injury, or complication which caused death.
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myelocytic leukemia
 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.

19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION none 20. AUTOPSY? YES NO

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) 2041

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from April 11, 1957, to May 12, 1957, that I last saw the deceased alive on May 12, 1957, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William T. Gross M.D. 23b. ADDRESS Ellis Fischer State Cancer Hosp Columbia, Mo 23c. DATE SIGNED May 12, 1957

24a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Home 24b. DATE May 15/1957 24c. NAME OF CEMETERY OR CREMATORY Arrow Rock 24d. LOCATION (City, town, or county) (State) Arrow Rock, Missouri

DATE REC'D BY LOCAL REG. May 15 1957 REGISTRAR'S SIGNATURE Mrs R.E. Palmer 31 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodman & Baller Beausville Mo.

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

105
05

RECEIVED 5-21-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 5-21-51 _____

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.....
Student Embalmer

Signed *J. Goodman*

Licensed Embalmer No. 1178

P. O. Address *Boonville 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.