

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7662**

BIRTH NO. 02942 REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 105

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CAPE GIRARDEAU		c. LENGTH OF STAY (In this place) 8 Days	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ILLMO		1000	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSP.		d. STREET ADDRESS (If rural, give location) --	

3. NAME OF DECEASED (Type or Print)	a. (First) DEBORAH	b. (Middle) IRIS	c. (Last) WELLS	4. DATE OF DEATH (Month) (Day) (Year) March 22, 1952
-------------------------------------	---------------------------	-------------------------	------------------------	-------------------------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec 10, 1951	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR 3 Months	IF UNDER 1 YEAR 12 Days	IF UNDER 1 MIN. 0 Hours	IF UNDER 1 MIN. 0 Min.
----------------------	-------------------------------	-----------------------------------------------------------------------------	--------------------------------------	------------------------------------------	---------------------------------	--------------------------------	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Cape Girardeau, Missouri	12. CITIZEN OF WHAT COUNTRY? U S
-----------------------------------------------------------------------------------------------------------	---------------------------------------------	---------------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME Robert Wells	13b. MOTHER'S MAIDEN NAME Jewell Sander	14. NAME OF HUSBAND OR WIFE ----
----------------------------------------	------------------------------------------------	-----------------------------------------

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. None	17. INFORMANT'S SIGNATURE OR NAME Robert Wells	ADDRESS Illmo, Mo
--------------------------------------------------------------------------------------------------------------------	-------------------------------------	-------------------------------------------------------	--------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 Days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Accident		<i>with Wells</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital Heart Disease 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	19b. MAJOR FINDINGS OF OPERATION 7544	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) (Minute)	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 **Feb 14, 1952**, to **March 22, 1952**, that I last saw the deceased alive on **March 22, 1952**, and that death occurred at **7:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Type and title) Chas. J. Kerlied M.D.	23b. ADDRESS Cape Girardeau, Mo	23c. DATE SIGNED 3/24/52
--------------------------------------------------------------	----------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 24, 1952	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	24d. LOCATION (City, town, or county) (State) Commerce Twp Missouri
---------------------------------------------------------	---------------------------------	------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 3-31-52	REGISTRAR'S SIGNATURE L. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE Disploughoff	ADDRESS Illmo, Mo
-----------------------------------------	--------------------------------------------	------------------------------------------------------	--------------------------

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

164

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 Oliver A. Amick

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.