

FILED AUG 27 1954

THE DIVISION OF HEALTH OF THE STATE OF KANSAS
STANDARD CERTIFICATE OF DEATH

State File No. 27822

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3787

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Nemaha	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) Unk.	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #1		e. STREET ADDRESS (If rural, give location) 8150 8	

3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) ANN c. (Last) WELLS		4. DATE OF DEATH (Month) (Day) (Year) AUG. 3, 54	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep. 29, 1924
9. AGE (In years last birthday) 29		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and State or Foreign Country) Falls City, Neb	

13a. FATHER'S NAME Charles Hanson	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Lowell D Wells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME Coroners Office Kansas City, Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Intercranial Trauma (Concussion)		INTERVAL BETWEEN ONSET AND DEATH 2:16 4 20
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Auto Trauma		
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 checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson T. & Co. Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 8-1 54	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Two Car Collision

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. Owens <i>Hugh H. Owens Coroner</i>	23b. ADDRESS 1034 Piatt Bldg	23c. DATE SIGNED 8-3-54
24a. BURIAL CREMATION REMOVAL (Specify) Removal	24b. DATE Aug. 3, 54	24c. NAME OF CEMETERY OR CREMATORY Falls City, Nebraska

DATE REC'D BY LOCAL REG. 8-3-54	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Shelton J. ...	ADDRESS Falls City, Neb
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(Licensed Embalmer's Statement on Reverse Side)

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

JAN 11 1957

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.....
Signature of Student Embalmer

Signed *John B. Caputo*

Licensed Embalmer No.....4273

P. O. AddressK.C., No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.