No. 300
10.48

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

FILED AUG 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23188

BIRTH NO. _____ REG. DIST. NO. 279 PRIMARY REG. DIST. NO. 5956 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY ~~LINCOLN~~ PIKE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) PAYNESVILLE
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

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

3. NAME OF DECEASED (Type or Print)
a. (First) KATHARINE b. (Middle) BERKLEY c. (Last) WELLS

4. DATE OF DEATH (Month) (Day) (Year) AUG. 5, 1955

5. SEX female

6. COLOR OR RACE white

7. ~~MARRIED, NEVER MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify) WIDOWED

8. DATE OF BIRTH OCT. 11, 1871

9. AGE (In years last birthday) 83 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (City and State or Foreign Country) PAYNESVILLE, Mo.

12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME JOSEPH MELOAN

13b. MOTHER'S MAIDEN NAME MARGARET HELEN PATTON

14. NAME OF HUSBAND OR WIFE THOS. C. WELLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S SIGNATURE OR NAME JOSIE HOPKE - PAYNESVILLE, MO. 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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 MO.

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

19b. MAJOR FINDINGS OF OPERATION 332 X

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

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* 5-1, 1955, *to* 8-5, 1955, *that I last saw the deceased alive on* 7-4, 1955, *and that death occurred at* 12:A. m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] (Degree or title) MD

23b. ADDRESS Elsberry Mo

23c. DATE SIGNED 8/6/55

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 8-7-55

24c. NAME OF CEMETERY ~~OR CREMATORY~~ GREENWOOD

24d. LOCATION (City, town, or county) (State) CLARKSVILLE, Mo

DATE REC'D BY LOCAL REG. 8-9-55

REGISTRAR'S SIGNATURE Reba Rickard

25. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS Elsberry, Mo

(Licensed Embalmer's Statement on Reverse Side)

AUG 17 1955

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 [illegible]

Licensed Embalmer No. 4012

P. O. Address Elsberry, 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.