

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35583**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2392**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Manchester</b>	c. LENGTH OF STAY (in this place) <b>4 mos</b>	c. CITY OR TOWN <b>Claytoner Mo.</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Manchester Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>201 Brighton Way</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>Samuel</b>	b. (Middle) <b>Perry</b>	c. (Last) <b>Wells</b>	(Month) <b>Oct.</b>	(Day) <b>18,</b>	(Year) <b>1955</b>

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 9, 1866</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Mgr. Whse-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hayette Tobacco Whse.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Harrison County, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>Wm. Mattleson Wells</b>	13b. MOTHER'S MAIDEN NAME <b>(Unk) Cord</b>	14. NAME OF HUSBAND OR WIFE <b>Maggie Owens Wells</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>406410-8908A</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Col. Emery Wells</b>	ADDRESS <b>201 Brighton Way</b>
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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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CHRONIC MYOCARDITIS</b>  ANTECEDENT CAUSES DUE TO (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c) <b>SEXUALITY</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YEARS</b>  <b>SEVERAL YEARS</b>	
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19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>4500</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **July 1, 1955**, to **Oct. 18, 1955**, that I last saw the deceased alive on **Oct. 17, 1955**, and that death occurred at **6 A m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>B. R. Loving M.D.</b> (Degree or title)	23b. ADDRESS <b>BALLWIN, MO.</b>	23c. DATE SIGNED <b>10-18-55</b>
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24a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Oct. 18, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lexington Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Lexington, Ky.</b>
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DATE REC'D BY LOCAL REG. <b>10-18-55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Domb...</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>G. Alexander &amp; Sons</b>	ADDRESS <b>6175 Belmont</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr Loving  
12-2  
Baldwin Mo.

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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 *James E. McCulloch*.....

Licensed Embalmer No. *246*

P. O. Address *6175 D*

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.