

Health, Welfare, Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED DEC 7-1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38305
STATE FILE NUMBER
4985
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> <u>JACKSON</u> COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	b. CITY OR TOWN <u>507</u> <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>		Length of stay in (b) <u>30 years</u> 14 days	d. STREET ADDRESS (If outside, give location) <u>3744 Indiana</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>A.</u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1898</u>	9. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	11. BIRTHPLACE (City and state or country) <u>Stuartsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Wells</u>			14. MOTHER'S MAIDEN NAME <u>unknown Coy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>187 16 9635</u>	17. INFORMANT Address <u>Mrs. Frances A. Wells, Kansas City, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO (b) <u>Spontaneous</u> DUE TO (c) <u>Seems of this hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>5410</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		STATE
21. I attended the deceased from <u>7-10-1950</u> to <u>11/16/56</u> and last saw ^{her} him alive on <u>11/16/56</u> Death occurred at <u>3:45A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Delon A. Williams</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>806 P. of Hwy</u>		22c. DATE SIGNED <u>11/17/56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/19/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Raytown, Mo.</u>	
24. FUNERAL DIRECTOR <u>Geo. C. Carson</u>		ADDRESS <u>Independence, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-17-56</u>	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..... *J. H. Gibson*

Licensed Embalmer No... 48

P. O. Address *Indep*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.