

Health, Welfare & Public Service  
 300  
 1-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED AUG 1 1958

58-027290  
 STATE FILE NUMBER 7236

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chronic Hosp</i>				Length of stay in 1b <i>2 1/2</i>		d. STREET ADDRESS (If outside, give location) <i>5500 Arsenal</i>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>James</i> Last <i>Wells</i>				4. DATE OF DEATH Month <i>06</i> Day <i>24</i> Year <i>1958</i>		5. SEX <i>Male</i>	
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <i>65</i> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>house</i>		11. BIRTHPLACE (City and state or country) <i>Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wells</i>				14. MOTHER'S MAIDEN NAME <i>Wells</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give description of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>H. G. Wells Coroner Clerk</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1. Cardiac Hypertrophy</i> <i>2. fracture of left femur</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Suffered in fall at St Louis Chronic Hosp</i> DUE TO (c) <i>all or abt June 5 - 1958</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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) <i>Fall at Chronic Hosp - E904.745 000</i>					
20c. TIME OF INJURY Hour <i>6-7-58</i> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>HOSPITAL</i>		20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>	
21. I attended the deceased from <i>5-15</i> to <i>5-15</i> and last saw her/him alive on <i>5-15</i> Death occurred at <i>5-15</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <i>Joseph J. Spary</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>7/17/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-31-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>	
24. FUNERAL DIRECTOR <i>Rowland-Aker Mortuary Service</i> 4104 Menobester Ave. St. Louis 10 Mo.				25. DATE RECD. BY LOCAL REG. <i>JUL 23 58</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i>	

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**