

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010593

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 12

FILED MAR 23 1959

300
1-57-1

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Charles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Charles</u> ¹⁹²³
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sycamore Trailer</u>		Length of stay in 1b <u>5 months</u>	d. STREET ADDRESS (If outside, give location) <u>Sycamore Trailer</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u></u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>14</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1900</u>
9. AGE (In years last birthday) <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	11. BIRTHPLACE (City and state or country) <u>Cambridge Springs, N.Y.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Residential</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Wells</u>		13b. MOTHER'S MAIDEN NAME <u>Pearl Wells</u>	14. NAME OF HUSBAND OR WIFE <u>Celest Tracy</u>
15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>310-22-6734</u>	17. INFORMANT <u>Mrs. Celest Wells, St. Charles, 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>Pneumonia, bronchial</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>metastatic carcinoma of lung</u> DUE TO (c) <u>carcinoma of tongue</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1419</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>7 months</u> <u>8 months</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.) <u>1419</u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>			
20d. INJURY OCCURRED WHILE AT <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.) <u></u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>
21. I attended the deceased from <u>August, 1958</u> to <u>March, 1959</u> and last saw ^{her} alive on <u>16 March 59</u> Death occurred at <u>10:40 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James F. Nickel, M.D.</u> (Degree or title)		22b. ADDRESS <u>4753 Maryland Ave</u> <u>St. Louis, Mo.</u>	22c. DATE SIGNED <u>16 Mar 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Mar. 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Omaha, Nebraska</u>
24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons Co.,</u> ADDRESS <u>St. Charles, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 16 - 59</u>	26. REGISTRAR'S SIGNATURE <u>Maree Wilson</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

vector, coroner, etc. must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 R. Amalou*
Licensed Embalmer No. *4830*
P. O. Address *St. Charles*

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.