

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959 042

59-031578

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 921

STATE FILE NUMBER

|                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    |                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                      |                                                                                          |                                                                                                                                                          |                                                          | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |                                                                                           |                                                                    |                                  |
| a. COUNTY <u>Buchanan</u>                                                                                                                                                                                                                              |                                                                                          | b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>                                                                      |                                                          | c. CITY OR TOWN <u>St. Joseph</u>                                                            |                                                                                           | d. STREET ADDRESS (if outside, give location) <u>1912 Bartlett</u> |                                  |
| Length of stay in 1b <u>Life</u>                                                                                                                                                                                                                       |                                                                                          | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        |                                                          | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>           |                                                                                           |                                                                    |                                  |
| 3. NAME OF DECEASED (Type or print)                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                          |                                                          | 4. DATE OF DEATH                                                                             |                                                                                           |                                                                    |                                  |
| First <u>Lee</u>                                                                                                                                                                                                                                       |                                                                                          | Middle <u>Roy</u>                                                                                                                                        |                                                          | Last <u>Wells</u>                                                                            |                                                                                           | Month <u>September</u> Day <u>7</u> Year <u>1959</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 9, 1898</u>                     | 9. AGE (last birthday) <u>60</u>                                                             | IF UNDER 1 YEAR                                                                           |                                                                    | IF UNDER 24 HR                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>                                                                                                                                             |                                                                                          | 10b. KIND OF BUSINESS OR INDUSTRY <u>Armour &amp; Co.</u>                                                                                                |                                                          | 11. BIRTHPLACE (City and state or country) <u>Buchanan County, Mo.</u>                       |                                                                                           | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>                          |                                  |
| 13a. FATHER'S NAME <u>Manson Wells</u>                                                                                                                                                                                                                 |                                                                                          |                                                                                                                                                          | 13b. MOTHER'S MAIDEN NAME <u>Fannie Bramley</u>          |                                                                                              |                                                                                           | 14. NAME OF HUSBAND OR WIFE <u>Myrtle Wells</u>                    |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>                                                                                                                                                                            |                                                                                          | 16. SOCIAL SECURITY NO. <u>486-24-9256</u>                                                                                                               |                                                          | 17. INFORMANT Address <u>Eugene Wells Route 6, St. Joseph, Mo.</u>                           |                                                                                           |                                                                    |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                  |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Portal Cirrhosis</u>                                                                                                                                                                                                            |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    | <u>4 months</u>                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                                                                                                                                             |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    |                                  |
| DUE TO (b) _____                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    |                                  |
| DUE TO (c) _____                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                                      |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              | PART III. If deceased was female was there a pregnancy in last 90 days.                   |                                                                    |                                  |
|                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                    |                                  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                         | 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 checked="" type="checkbox"/>                                                                                                                                      | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                                                                                                                          | 20f. CITY, TOWN, OR LOCATION                             |                                                                                              | COUNTY                                                                                    | STATE                                                              |                                  |
| 21. I attended the deceased from <u>1958</u> to <u>Sept. 7, 59</u> and last saw <u>him</u> alive on <u>Sept. 7, 1959</u> . Death occurred at <u>1:50</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                          |                                                                                                                                                          |                                                          |                                                                                              |                                                                                           |                                                                    |                                  |
| 22a. SIGNATURE (Degree or title) <u>Clement C. Clark M.D.</u>                                                                                                                                                                                          |                                                                                          |                                                                                                                                                          |                                                          | 22b. ADDRESS <u>St. Joseph, Mo.</u>                                                          |                                                                                           | 22c. DATE SIGNED <u>Sept. 8, 59</u>                                |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                |                                                                                          | 23b. DATE <u>Sept. 9, 1959</u>                                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> |                                                                                              | 23d. LOCATION (City, town, or county) (State) <u>Ladson, Missouri</u>                     |                                                                    |                                  |
| 24. FUNERAL DIRECTOR OR ADDRESS <u>Clark Funeral Home</u>                                                                                                                                                                                              |                                                                                          |                                                                                                                                                          | 25. DATE RECD. BY LOCAL REG. <u>Sept. 15, 1959</u>       |                                                                                              | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>                                      |                                                                    |                                  |

DOCUMENT

C.C. DeMont Medical Certification

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Earl A. Clark

Licensed Embalmer No. 4234

P. O. Address St. George

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

ST. GEORGE