

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034480**

**FILED VS OCT 8 1959**

**2 8923**

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4527 Varrelman Ave.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4527 Varrelman Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD C. WELLS				4. DATE OF DEATH Month Day Year Sep. 27 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-12-1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker-Self Employed			10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Thomas R. Wells			13b. MOTHER'S MAIDEN NAME Isa P. Johnson			14. NAME OF HUSBAND OR WIFE Nonie Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO.		17. INFORMANT Address Nonie Wells 4527 Varrelman Ave.		
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>Hypertensive Cardi. Vasc. Disease</i> DUE TO (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>420.1</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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) <i>Cerebral Thrombosis</i>					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 Month, Day, Year a.m. p.m.							
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		COUNTY	STATE
21. I attended the deceased from <i>10/16/59</i> to <i>9/27/59</i> and last saw him alive on <i>9/1/59</i> . Death occurred at <i>11:55 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Robert G. Farrell M.D.</i>				22b. ADDRESS <i>624 N. Union</i>		22c. DATE SIGNED <i>9/28/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-30-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway				25. DATE RECD. BY LOCAL REG. SEP 28 '59		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i> <i>228B</i>	

DOCUMENT

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Edwin A. McArthur

Licensed Embalmer No. 3024

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.