

JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1959

59-039234

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 422

EMENDED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Cape Gir.</u>			
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>Jackson</u>		Length of stay in lb <u>69 yrs</u>		c. CITY OR TOWN <u>Jackson</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>1008 Morton St</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1008 Morton St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OTZO</u> Middle <u>Leonard</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>13</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1889</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
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>light plant</u>		11. BIRTHPLACE (City and state or country) <u>Gordonville, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>John W. Wells</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Summers</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Hattie Wells, Jackson, 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>Cardiac Failure</u>						<u>18-24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>							
DUE TO (c) <u>Pneumonia</u>							
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.		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 <u>8-1-59</u> to <u>11-13-59</u> and last saw him alive on <u>11-12-59</u> . Death occurred at <u>1:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Walter D. Kasten D.O.</u>				22b. ADDRESS <u>Jackson, MO</u>		22c. DATE SIGNED <u>11-17-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov 15, 1959</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson MO.</u>	
24. FUNERAL DIRECTOR <u>J.C. Cravatte</u>		ADDRESS <u>Jackson, MO</u>		25. DATE RECD. BY LOCAL REG. <u>11-18-1959</u>		26. REGISTRAR'S SIGNATURE <u>Drew Kasten</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6561 S 2 MON STA

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 *Wm C. Cramer*

Licensed Embalmer No. 437

P. O. Address Jackson, W.

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.