

VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043151

FILED VS. DEC 15 1959 360

Primary Registration District No. 6225 Registrar's No. 200

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> Length of stay in lb <u>629-28d.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Hosp. #</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Barton</u> c. CITY OR TOWN <u>Lamar</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>unk.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>L (?)</u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>59</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>8-10-84</u>	9. AGE (last birthday) <u>75</u>	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, except retired) <u>farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Cedar Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Richard G. Wells</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah L. Henson</u>			14. NAME OF HUSBAND OR WIFE <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>492-20-7177</u>		17. INFORMANT Address <u>Records Mo. State Hosp #3 Nevada, 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>Chronic Arteriosclerotic Cardiovascular Disease</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) <u>Chronic Brain Syndrome Assoc. with Senile Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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>9-1-59</u> to <u>12-3-59</u> and last saw ^{her} him alive on <u>12-2-59</u> Death occurred at <u>3:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. Combs M.D.</u>			22b. ADDRESS <u>Nevada, Missouri</u>			22c. DATE SIGNED <u>12-3-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-5-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>LAMAR, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Chiles Funeral Home - LAMAR, MO</u>			25. DATE RECD. BY LOCAL REG. <u>12-8-1959</u>		26. REGISTRAR'S SIGNATURE <u>Arnold E. Jorrey</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 28 1959

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 Charles Chiles

Licensed Embalmer No. 3473

P. O. Address San Marino

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.