

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 46 0 7 0

FILED VS DEC 21 1959

211326

STATE FILE NUMBER
'59 0 46 0 7 0

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Wood River Twp.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) Route 1	

3. NAME OF DECEASED (Type or print) First Middle Last James W. Wells	4. DATE OF DEATH Month Day Year December 6, 1959
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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 3/1/1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Roofing	11. BIRTHPLACE (City and state or country) Cecilton, Maryland	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Joseph Wells	13b. MOTHER'S MAIDEN NAME Merilla Jeffery	14. NAME OF HUSBAND OR WIFE Jessie
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 481-22-1328	17. INFORMANT Address Jessie Wells, Rt. East Alton, Ill.
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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)	Pulmonary edema	1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) congestive heart failure, acute	1 hour
	DUE TO (c) hypertension of chronic glomerulonephritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592x		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.) 592x
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 **6 APR 59** to **6 DEC 59** and last saw ^{her} ~~him~~ live on **6 DEC 59**
Death occurred at **5:30 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James F. Nichel, M.D.	22b. ADDRESS # 52 Woodland Pl. St Louis 8, Mo.	22c. DATE SIGNED DEC 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-9-59	23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Omaha, Nebraska
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24. FUNERAL DIRECTOR ADDRESS Smith Funeral Home, Wood River, Ill.	25. DATE RECD. BY LOCAL REG. DEC 7 1959	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Illinois

X

Wood River

Illinois

X

Route 1

X

St. Louis Hospital

December 6, 1928

White

..

James

X

2/1/1928

White

Male

..

Section, St. Louis

looking

Contractor

lease

White

Joseph Wells

St. Louis, Ill.

28-2-1928

..

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 Warner L. Coffman

Licensed Embalmer No. 6119

P. O. Address Wood River

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.

Illinois

St. Louis

2-2-28

White

St. Louis, Ill.