RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-007187

STATE FILE NUMBER

FILED VS FEB 16 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe — Length of stay in 1b: 7 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 102 Lilly St. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Livingston
c. CITY OR TOWN Chillicothe — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 102 Lilly St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: JOSEPH Middle: Last: WELLS

4. DATE OF DEATH Month: February Day: 6, Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/20/1881
9. AGE (last birthday): 78
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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Texas (City Unknown)
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOHN WELLS
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: Myrtle Keith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Edna Marsh; Chula, Missouri — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
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): Bronchiectasis.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 May 1959, to Feb 6-60 and last saw her/him alive on Feb 4-60
Death occurred at 4:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph F. Gale (Degree or title) M.D.
22b. ADDRESS Chillicothe, Mo.
22c. DATE SIGNED 2-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/8/60
23c. NAME OF CEMETERY OR CREMATORY: Wheeling Cemetery
23d. LOCATION (City, town, or county) (State): Wheeling, Missouri

24. FUNERAL DIRECTOR ADDRESS: NORMAN FUNERAL HOME: Chillicothe, Mo.
25. DATE RECD. BY LOCAL REG.: 2/8/60
26. REGISTRAR'S SIGNATURE: Frances B Neill

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 5063

P. O. Address Chillicothe,

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