

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

OF PUBLIC HEALTH AND WELFARE

REGISTRATION DISTRICT NO. 38 PRIMARY REGISTRATION DISTRICT NO. 3006 REGISTRAR'S NO. 600

STATE FILE NUMBER 60-037471

DEED FILED VS OCT 31 1960

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. Francis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>Leadwood</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Missouri Med. Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Wayne</u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>60</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/60</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Farmington Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Chester Wells</u>		13b. MOTHER'S MAIDEN NAME <u>Virginia Mosier</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Medical Record</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>CARDIO-RESPIRATORY INSUFFICIENCY</u> DUE TO (b) <u>CYANOTIC HEART DISEASE</u> DUE TO (c) <u>PROBABLE TRANSPOSITION OF GREAT VESSELS</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 <u>1:10</u> Month, Day, Year <u>10/27/60</u>		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 <u>Leadwood, Mo.</u>		20g. COUNTY <u>Boone</u>		20h. STATE <u>Mo</u>	
21. I attended the deceased from <u>10/24/60</u> to <u>10/27/60</u> and last saw ^{him} alive on <u>10/27/60</u> Death occurred at <u>1:10</u> <u>P</u> .m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>George Z Baker M.D.</u>			22b. ADDRESS <u>MM MED CENTER, COLUMBIA</u>		22c. DATE SIGNED <u>10/27/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leadwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Leadwood, Mo.</u>
24. FUNERAL DIRECTOR <u>Parker Funeral Service</u>		ADDRESS <u>Columbia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 27, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. W. Phillips

Licensed Embalmer No. *4897*

P. O. Address *Columbus*

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