

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

-60-040971
STATE FILE NUMBER

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 122

1. PLACE OF DEATH a. COUNTY Barton				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Barton				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lamar		Length of stay-in 1b		c. CITY OR TOWN Lamar		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barton Co. Memorial Hosp.			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 102 W. 15th St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ED Last WELLS				4. DATE OF DEATH Month December Day 7 Year 1960				
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (City and state or country) Nashville, Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME John Wells			13b. MOTHER'S MAIDEN NAME Elizabeth Evilsizer			14. NAME OF HUSBAND OR WIFE - None		
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. None		17. INFORMANT Address Mr. Claude Wells, Carthage, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Recurrent						one year ago		
DUE TO (c) old age								
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 9:00 a.m. Month, Day, Year Dec 10 1960		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Dec 10 1960 to Dec 7 1960 and last saw her alive on Dec 7 1960 Death occurred at 9:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE D R Evedner M.D. (Degree or title)			22b. ADDRESS LAMAR			22c. DATE SIGNED 12-8-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Iantha Cemetery		23d. LOCATION (City, town, or county) (State) Iantha, Missouri		
24. FUNERAL DIRECTOR ADDRESS Chiles Funeral Home, Lamar, Mo.			25. DATE RECD. BY LOCAL REG. DEC 9 '60		26. REGISTRAR'S SIGNATURE Marie Kovarik			

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

Student _____
Signature of Student Embalmer

Signed Clarence H. Chiles

Licensed Embalmer No. 347

P. O. Address San Antonio, TX

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