

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 6 1961

157

Primary Registration District No. 3028

Registrar's No.

262-60-046535

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper															
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 2 yrs		c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 1069 S. Garrison Ave			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 1069 S. Garrison Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First FLORENCE Middle WELLMAN Last				4. DATE OF DEATH Month Dec. Day 24, Year 1960															
5. SEX female		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-17-1882		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) Coventry, Conn.		12. CITIZEN OF WHAT COUNTRY USA											
13a. FATHER'S NAME not available				13b. MOTHER'S MAIDEN NAME not available				14. NAME OF HUSBAND OR WIFE Graham O. Wellman											
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 R.O. Thurbar, Windsor, Conn													
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>Heart block</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Embolicism</u> DUE TO (c) <u>Traumatic injury to groin 2 wks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>											
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 Month, Day, Year a.m. p.m.		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>12-1-60</u> to <u>12-24-60</u> and last saw her/him alive on <u>12-24-60</u> Death occurred at <u>11:20</u> am on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>Albert B. Wheeler</u> DO						22b. ADDRESS 1069 Garrison, Carthage, Mo				22c. DATE SIGNED 12-24-60									
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE 12-27-60		23c. NAME OF CEMETERY OR CREMATORY Newcomers Crematory				23d. LOCATION (City, town, or county) (State) Kansas City, Mo.											
24. FUNERAL DIRECTOR KNELL MORTUARY, Carthage, Mo				25. DATE RECD. BY LOCAL REG. Dec. 27, 1960		26. REGISTRAR'S SIGNATURE <u>[Signature]</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 by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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