

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 5 1967

-60-048222

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 3735

DEED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		Length of stay in lb <u>15 Days</u>	c. CITY OR TOWN <u>Flat River.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1951 Bressie Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8 Chestnut St.</u> Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>(NMI)</u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Bloomsdale, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Tullock</u>			13b. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Jasper Wells(Dec)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>U.N. KNOWN</u>		17. INFORMANT <u>Fred Bequette Flat River, Mo.</u>		

DOCUMENT

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>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u>			
DUE TO (c) _____			
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 _____ 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 <u>Overland, Mo.</u>	COUNTY <u>Iron</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>Dec 10, 1960</u> to <u>Dec 21, 1960</u> and last saw her/him alive on <u>Dec 21, 1960</u> Death occurred at <u>11:40</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>J. Paul, M.D.</u>		22b. ADDRESS <u>Overland, Mo.</u>		22c. DATE SIGNED <u>12-21-60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bonne Terre Ceme.</u>		23d. LOCATION (City, town, or county) <u>Bonne Terre, Mo.</u>

BY AFFIDAVIT OF

24. FUNERAL DIRECTOR <u>Murphy Sparks Funeral Home Flat River.</u>	ADDRESS <u>12-27-60</u>	25. DATE RECD. BY LOCAL REG. <u>12-27-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	----------------------------	---	---

mm

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 Murphy Lepore

Licensed Embalmer No. 4276

P. O. Address Madison

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.