

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036034

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1062

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Length of stay in 1b <u>35 years</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>1002 Corby</u>		d. STREET ADDRESS (If outside, give location) <u>1002 Corby</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>A BURMAN WELLS</u>			4. DATE OF DEATH Month Day Year <u>October 20, 1961</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/1886</u>
9. AGE (last birthday) <u>75</u>		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) <u>Retired accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Skidmore, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>William R. Wells</u>	
13b. MOTHER'S MAIDEN NAME <u>Maria D. Johnston</u>		14. NAME OF HUSBAND OR WIFE <u>Kitty Wells</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.	
17. INFORMANT <u>Mrs. Kitty Wells, 1002 Corby, St. Joseph, Mo.</u>		Address	
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>Cerebral vascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized</u>			<u>years.</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) <u>1. Parkinsonism 2. Emphysema</u>			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 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	COUNTY STATE
21. I attended the deceased from <u>August, 1954</u> to <u>Oct. 20, 1961</u> and last saw <u>xx</u> him alive on <u>Oct. 20, 1961</u>		Death occurred at <u>8:45 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Walter P. McDonald</u>		22b. ADDRESS <u>M. D. 301 N. 8th St., St. Joseph, Mo.</u>	22c. DATE SIGNED <u>10/27 '61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/23/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u>
24. FUNERAL DIRECTOR <u>Heston-Bowman, St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 25, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Woodell</u>

MEDICAL CERTIFICATION
W. P. McDonald, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 5804

P. O. Address 319 So 10th, Albany

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.