

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019501

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 79

FILED JUN 4 1962

VS 300  
Rev. 4/59

1 0570  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lincoln</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bedford</b>		Length of stay in lb <b>8 da</b>		c. CITY OR TOWN <b>Thalman Home</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lincoln County Memoria l Hospital</b>			d. STREET ADDRESS (If outside, give location) <b>5 mi North of Troy MO.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>WELLS</b>			4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10 1974</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>New Hope Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Wells</b>		13b. MOTHER'S MAIDEN NAME <b>Harriet Davis</b>		14. NAME OF HUSBAND OR WIFE <b>Susie Wells</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs Louis Cooper Troy MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>Diabetes</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>12 yrs</b> <b>12 yrs</b>
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 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 COUNTY STATE	
21. I attended the deceased from <u>Apr. 1 1949</u> to <u>May 18 1962</u> and last saw him alive on <u>May 17 62</u> Death occurred at <u>6:00 A</u> on the date stated above, and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) <b>H. J. Kelly D.O.</b>			22b. ADDRESS <b>Troy Mo</b>		22c. DATE SIGNED <b>5-18-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 20 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Reid Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lincoln County MO.</b>
24. FUNERAL DIRECTOR <b>DW McRay Troy Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-28-1962</b>	26. REGISTRAR'S SIGNATURE <b>Charlotte Leak</b>	

**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 D.W. McCoy

Licensed Embalmer No. 3586

P. O. Address Jaynes

**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.