

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-003151

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 44

FILED FEB 7 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Farmington</u>		Length of stay in 1b <u>8 mos</u>	c. CITY OR TOWN <u>St Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Easter Home of Ruth</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8005 Allen</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Wells</u>			4. DATE OF DEATH Month Day Year <u>February 1 1963</u>
5. SEX <u>Female</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>3/10/1873</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 <u>housework own home</u>	11. BIRTHPLACE (City and state or country) <u>Patterson, Ill.</u>
13a. FATHER'S NAME <u>Thomas Baxter</u>		14. NAME OF HUSBAND OR WIFE <u>Charles E 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. <u>[redacted]</u>	17. INFORMANT Address <u>Charles E Wells, St Louis, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <u>GANGRENE OF Left Leg</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED Arteriosclerosis</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>Chronic BRAIN Syndrome</u>			PART III. If deceased was female there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>[redacted]</u>	
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 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 <u>11-26-62</u> to <u>2-1-63</u> and last saw her <u>alive</u> on <u>1-29-63</u> Death occurred at <u>6:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>C E Carlston, M.D.</u>		22b. ADDRESS <u>Farmington, MO</u>	22c. DATE SIGNED <u>2-1-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2/3/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Tree Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Patterson, Ill.</u>
24. FUNERAL DIRECTOR <u>Miller Funeral Home, Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 1, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>

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 Paul K. Royal

Licensed Embalmer No. 4120

P. O. Address Farmington Mo

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.