

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007514

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 31

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0570

2 0570

3

4 1

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7 9

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9 97049

10 45

11 333

12 90-2

13 1-0

DATE AMENDED

8-8-63

8-8-63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

8-8-63

8-8-63

Medullary fracture of Cerebral Arteriosclerosis

Medullary fracture of Cerebral Arteriosclerosis

Prolonged Chronic Shock

Intertrochanteric fracture of right hip

right hip

Attending physician

8-8-63

8-8-63

DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

| | |
|---|---|
| FILED MAR 4 1963 | |
| 1. PLACE OF DEATH | |
| a. COUNTY Lincoln | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Troy | a. STATE Missouri b. COUNTY Lincoln |
| OR TOWN | c. CITY OR TOWN Troy |
| c. FULL NAME OF (If NOT in hospital, give location) 170 W. Bonfils | d. STREET ADDRESS (If outside, give location) 170 W. Bonfils |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED | |
| First Lou Middle Ellis Last Wells | 4. DATE OF DEATH Month February Day 27 Year 1963 |
| 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 2/16/1878 |
| 9. AGE (last birthday) 85 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife |
| 10a. USUAL OCCUPATION | 10b. KIND OF BUSINESS OR INDUSTRY home duties |
| 11. BIRTHPLACE (City and state or country) ? | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Alfred Weeks | 13b. MOTHER'S MAIDEN NAME Martha Mounce |
| 14. NAME OF HUSBAND OR WIFE Albert Wells | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No |
| 16. SOCIAL SECURITY NO. None | 17. INFORMANT D George Wells-Troy, Missouri |
| 18. CAUSE OF DEATH (Enter only one cause per line) | |
| PART I. DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| DUE TO (b) | |
| 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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Troy, Missouri |
| 21. I attended the deceased from 1-25-62 to 2-27-63 and last saw her ^{home} alive on 2-26-63 Death occurred at 5:10 pm on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE Addison Hornsby Jr | 22b. ADDRESS Troy, Mo |
| 22c. DATE SIGNED 2-28-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/2/1963 |
| 23c. NAME OF CEMETERY OR CREMATORY Auburn Cemetery | 23d. LOCATION (City, town, or county) (State) Auburn, Missouri |
| 24. FUNERAL DIRECTOR Temper-Marsh Funeral Home | 25. DATE RECD. BY LOCAL REG. 2-28-1963 |
| 26. REGISTRAR'S SIGNATURE Charlotte Leek | |

MAR 16 1963

MAR 22 1963

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 Carlton J. Pitman

Licensed Embalmer No. 4974

P. O. Address Leventville

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.