

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026510

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** County Registration District No. **1003** Registrar's No. **6377** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY - - -		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b	c. CITY OR TOWN Affton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 8532 Wilstead		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Kellogg Middle Agnew Last Wells			4. DATE OF DEATH Month June Day 17 Year 1963		5. SEX M			6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-12-17	9. AGE (last birthday) 45	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principle				10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (City and state or country) Sioux City, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Harvey D. Wells				13b. MOTHER'S MAIDEN NAME Hellen M. Kellogg			14. NAME OF HUSBAND OR WIFE Jeanne Bromeling Wells						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Jeanne B. Wells 8532 Wilstead							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction								INTERVAL BETWEEN ONSET AND DEATH 2 days					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4201								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		COUNTY		STATE					
21. I attended the deceased from 1955 to 6-17-63 and last saw her/him alive on 6-16-63 . Death occurred at 4:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Albert J. Grade M.D. (Degree or title)				22b. ADDRESS 3606 GRAYONS			22c. DATE SIGNED 6-17-63						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-19-63		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri							
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY ADDRESS SAM				25. DATE RECD. BY LOCAL REG. JUN 17 1963		26. REGISTRAR'S SIGNATURE Loal Smith M.D.							

VS 300 Rev. 4/59

DATE AMENDED

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2 **40093A**
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4 **0**
5 **1**
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7 **1**
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12 **73-0**
13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Dr. Matzus
3603 Gravois
PR. 2-7380

Phone toll free 1 to 4

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 *Brian C. Brannon*

Licensed Embalmer No. *4764*

P. O. Address *St Louis, 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.