

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

5241

1. PLACE OF DEATH

County Jackson
Township Kew
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. Kansas City General Hospital)

File No. 859
Registered No. 859
St. _____ Ward _____

2. FULL NAME

Wells James
(a) Residence. No. 715 1/2 E 15th St. 2 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-31-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 3 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) California

10. NAME OF FATHER Wm Wells

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Phoebe Loney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

14. INFORMANT Reast Lalerh (Address) Kansas City Genl Hosp.

15. FILED 7/26 19 30 M. M. Corvud REGISTRAR ant

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-23-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-22- 1930, to 2-23- 1930 that I last saw him alive on 2-22- 1930, and that death occurred, on the date stated above, at 10:12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cardiac Decompensation
45D

CONTRIBUTORY (SECONDARY) 90B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) P E Welleau, M. D.

2-23 1930 (Address) Supl. K. G. Genl Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hopkemo Mo DATE OF BURIAL 7/27 1930

20. UNDERTAKER W. Maest ADDRESS 916 East 15th

