PR 23 1930

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

Do not use this space.

7791

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No. 334
Township — Primary Registration District No. 1001 — Registered No.
City St.Joseph, (No. St.Joseph's Hospital St. Ward)

2. FULL NAME Howard Leslie Wells
(a) Residence. No. 624 No.5th.St. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar,31,1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	35	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk,U.S.Postal Service
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer St.Joseph Post Office

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rushville,Mo.

PARENTS
10. NAME OF FATHER Bradley Wells
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Buchanan Co,Mo.
12. MAIDEN NAME OF MOTHER Savannah M.Canter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Rushville,Mo.

14. INFORMANT Mrs.Etha Wells
(Address) 624 No.5th.St.

15. FILED MAR 15 1930 19 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar,12,1930 19

17. I HEREBY CERTIFY, That I attended deceased from February 9, 1930, to March 12, 1930 that I last saw him alive on March 12, 1930, and that death occurred, on the date stated above, at 12.20 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
abscess of right lung
210M
1148
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Punctured lung - auto (Fractured rib.)
accident (duration) yrs. mos. ds.
Happened in County.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [signature], M. D.
3-14, 1930 (Address) Kirkpatrick Bldg St Joseph Mo.

*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	DATE OF BURIAL
Ashland Cemetery	Mar,15, 1930

20. UNDERTAKER	ADDRESS
Walter Meinhoffer	1302 Faraon St.

Dr. Hartigan

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH.
County: Buchanan — Registration District No.: 85 — File No.: 7791
Township: — Primary Registration District No.: 1001 — Registered No.: 334
City: St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME: Howard Leslie Wells

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 9/20 19 30 — John G. Ott — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h. ..... alive on ..... 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess of right lung
Punctured lung, auto accident
happened in country
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) auto accident — died not more than one
Auto injuries only — (duration) hour yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Frank Hartigan M. D.
9/20, 1930 (Address) St. Joseph - Mo

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

THEY ARE COMPLETE AS PRESCRIBED BY LAW
WILL NOT RECEIVE A FEE FOR CERTIFICATE

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