

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

Do not use this space.

30413

**1. PLACE OF DEATH**

County Wayne  
Township Mt. Grove  
City Jeremiah M. Wells

Registration District No. 908  
Primary Registration District No. #547  
6222

File No. 40  
Registered No. 40  
St.          Ward         

**2. FULL NAME**

Jeremiah M. Wells

(a) Residence No.          St.          Ward           
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 15 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 4. 1832

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
9-8      9      19

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.           
10. Date deceased last worked at this occupation (month and year)          11. Total time (years) spent in this occupation         

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Castle Ind

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penna

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mr. Ida Wells  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Hill Crest DATE 8-24-1931

19. UNDERTAKER Bollinger Funeral Home  
(ADDRESS)

20. FILED 8/31 1931 J. H. Hession  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

9-18-31

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-23-1931

22. I HEREBY CERTIFY, That I attended deceased from 8/17, 1931, to 8/23, 1931  
I last saw          alive on 8/20, 1931. Death is said to have occurred on the date stated above, at          m.

The principal cause of death and related causes of importance were as follows:

Injury (accidental) Date of onset           
June fall in house  
1869  
1945  
Other contributory causes of importance:         

Name of operation None Date of           
What test confirmed diagnosis? Cholera Was there an autopsy?         

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?          Date of injury         , 19          
Where did injury occur?          (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall in his house  
Nature of injury General shock from fall

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify           
(Signed) R. A. Ryan, M. D.  
(Address) Mt. Grove

1945

1946

1947

1948

1949

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Wright Registration District No. 908 File No. \_\_\_\_\_  
 Township Min Grove Primary Registration District No. 6222 Registered No. 40  
 (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

NAME Jeremiah M. Wells

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 OR (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)

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 8/31 1931 J. M. Cabard REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23 1931

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 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:**

Injury (accidental)  
from fall in house  
or pipes over my  
or coffee on floor  
 (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (duration) \_\_\_\_\_ yrs. mos. ds.  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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 \_\_\_\_\_

SUPPLEMENTARY

I NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS REGIS

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