

AUG 10 1938

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

299461
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 284
(b) Township Clayton Primary Registration District No. 101 Registered No. 1349
(c) City Clayton (d) Street No. St. Louis County Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred Unavailable (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Wells

(a) Residence, No. 438 Leeton, Prospect Hill St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIFE OR WIDOWED HUSBAND OF (or) Katherine Wells
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 2, 1913
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 2 4
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Daborer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 1938 11. Total time (years) spent in this occupation Unk.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tuscaloosa County
Alabama

FATHER 13. NAME James Wells
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Utah County
Alabama

MOTHER 15. MAIDEN NAME Laura Lucious
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tuscaloosa County
Alabama

17. INFORMANT (NAME) Katherine Wells
(ADDRESS) 426 Leeton Avenue18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Aug. 12, 193819. FUNERAL DIRECTOR (NAME) Chas. Gales
(ADDRESS) 4107 Finney Avenue20. FILED AUG 10 1938 St. Louis County Hospital
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 6, 193822. I HEREBY CERTIFY, That I attended deceased from 7-29-38, 1938, to 8-6, 1938I last saw him alive on 8-6, 1938 Death is saidto have occurred on the date stated above, at 5:45 P.M.

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

Date of onset
Pulmonary Tuberculosis 1933
Pulmonary Hemorrhage Feb. 1938

Other contributory causes of importance:

Pneumothorax J. J. W.Name of operation _____ Date of 8-5-38What test confirmed diagnosis? _____ Was there an autopsy? No23. 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 _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify No(Signed) L. M. Conroy, M. D.(Address) St. Louis County Hospital

STATEMENT BY LICENSED EMBALMER

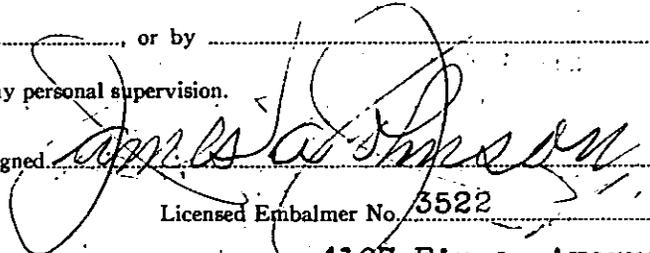
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

James A. Johnson

..... or by

Registered Apprentice No., working under my personal supervision.

Signed



Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue**
St. Louis, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29946
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Clayton Primary Registration District No. 101 Registered No. 1342
 (c) City Clayton (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Wells
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 2 1913

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>25</u>	<u>4</u>	<u>4</u>	<u>5</u>

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) _____

FATHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED S-10 1928 JR Meyer M.D. & P.P. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. 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:

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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 _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) L. M. Greenberg, M. D.
 (Address) St. Louis Co. Hoop

Date of onset _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCUPATION is very important.

S-29946