

DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

39327  
Do not use this space.

1. PLACE OF DEATH

(a) County: Clark Registration District No. 194  
 (b) Township: Washington Primary Registration District No. 1271  
 (c) City: \_\_\_\_\_ or \_\_\_\_\_ (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

H-2-4 Elizabeth Amanda Wells  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas J. Wells  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 5, 1858  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81 3 9  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 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) Scotland Co Missouri

FATHER 13. NAME Samuel Cox

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland Co Missouri

MOTHER 15. MAIDEN NAME Martha Eliza Standiford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knox Co. Missouri

17. INFORMANT (ADDRESS) Mrs Robert Witts  
Wyaconda Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cemetery Nov 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Karle  
Kahoka Mo.

20. FILED Dec 2 1939 Bessie Beathley  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 14 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1939, to Nov 14, 1939.  
 Last saw h. w. alive on Nov 14, 1939. Death is said to have occurred on the date stated above, at 6.05 PM.  
 The principal cause of death and related causes of importance were as follows:

Arterial cerebral hemorrhage

Date of onset

Other contributory causes of importance:  
arterial sclerosis  
Albiter 59

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) W. C. E. Todd, M.D.  
Williamson Mo.  
 (Address) \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 12-39-2202

Date Filed DEC 12 1939

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1023

P. O. Address Kahoka 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 this body is not embalmed, above space should be left blank.