

JAN 15 1940

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

45003
Do not use this space.

1. PLACE OF DEATH

(a) County WRIGHT Registration District No. 1122
(b) Township CLARK Primary Registration District No. 6226 Registered No.
(c) City (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred 6 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME CLARA A 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 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 THOMAS WELLS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE-24-1865

7. AGE YEARS 74 MONTHS 4 DAYS 23 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
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) NOVEMBER 10-39 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) DELEWARE CO. (STATE OR COUNTRY) INDIANA

FATHER 13. NAME JAMES LINN.

14. BIRTHPLACE (CITY OR TOWN) NEW YORK (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME NOT KNOWN.

16. BIRTHPLACE (CITY OR TOWN) NOT KNOWN. (STATE OR COUNTRY)

17. INFORMANT Thomas Wells (ADDRESS) MACOMB MO

18. BURIAL, CREMATION, OR REMOVAL PLACE MACOMB Cem. DATE NOV 19 1939

19. FUNERAL DIRECTOR (NAME) F.A. STEFFE (ADDRESS) MANFIELD MO.

20. FILED 12-1 1939 Royal Burnett Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV. 17 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1939, to Nov 17, 1939
I last saw him alive on Nov 17, 1939. Death is said to have occurred on the date stated above, at 8:24 p.m.
The principal cause of death and related causes of importance were as follows:

Intestinal obstruction
looped bowel

Date of onset Nov 16 1939

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? no
If so, specify
(Signed) W. J. Zimmerman DO
1939 (Address) Manfield Mo.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD.

V. S. NO. 30M-9-19-38 I X16603

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. 6,

District File Number 140-233

Date Filed JAN 12 1940

122A

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 *H.C. Steffe*.....

Licensed Embalmer No. 3221.....

P. O. Address *Manfield*.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

45-003
Do not use this space.

1. PLACE OF DEATH
 (a) County Wright Registration District No. 1122
 (b) Township Clark Primary Registration District No. 6226 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Clara A. 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 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.
	<u>74</u>	<u>4</u>	<u>23</u>	

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 _____, 19____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 700 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ 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:
Intestinal Obstruction
Acid Bowel
M. M. I.
 Other contributory causes of importance: _____
1226

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. A. Zimmerman, M. D.
 (Address) Madison

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

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

Local Registrar.

S-45003