

FILED MAY 20 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH15715  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Pemiscot 2. Registration District No. 655  
 (b) Township VIRGINIA 3. Primary Registration District No. 5872 Registered No. \_\_\_\_\_  
 (c) ~~St.~~ Steele (R.F.D.) (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

Charles H. Wells  
 (a) Residence, No. Pemiscot County 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 M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED (deceased) HUSBAND OF Nannie Wells (or) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 8, 1871  
 7. AGE YEARS 69 MONTHS 5 DAYS 4 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer  
 10. Date deceased last worked at this occupation (month and year) 3-1-40 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) CINCINNATI, OHIO  
(STATE OR COUNTRY)13. NAME (?) Wells, G14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)15. MAIDEN NAME Elizabeth (?)16. BIRTHPLACE (CITY OR TOWN) Locustland, Ohio  
(STATE OR COUNTRY)17. INFORMANT James Wells  
(ADDRESS) Steele, Pemiscot Co, Virginia Twp

18. BURIAL, CREMATION, OR REMOVAL

PLACE Hoyti, Mo DATE 4-13-194019. FUNERAL DIRECTOR (NAME) H. S. Smith  
(ADDRESS) Barthersville, Mo

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-12-194022. I HEREBY CERTIFY, That I attended deceased from 4-12-1940 to 4-12-1940I last saw him alive on 4-12-1940 Death is saidto have occurred on the date stated above, at 8:50 A.M.

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

① Decompensated rheumatic heart & mitral INSUFF. Date of onset 3-1-38  
 ② Hypostatic bronchopneumonia 4-7-40  
 ③ Generalized Arteriosclerosis 1-1-35

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

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) E. L. Taylor, M. D.(Address) Steele, Mo

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.

5-40-2

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**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.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18-718-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 655

Primary Registration District No. 5872

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemisco  
(b) City or town Virginia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... years, months or days)

3. (a) PRINT FULL NAME Chas H. Wells

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married divorced urd

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 4 If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 5/1-40 (b) L. J. Adams (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

REGISTRATION CERTIFICATION

20. DATE OF DEATH: Month 4 day 12 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature E. L. Taylor (M. D. or other)

Address St. Louis Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

