

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43738

JAN 25 1941 779
Registration District 779

Primary Registration District No. 60240

Registrar's No. 19

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Cantwell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: W. H. ...
(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 2

3. (a) PRINT FULL NAME Susan Elizabeth Wells
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Frank E. Wells Sr. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 10 1850
(Month) (Day) (Year)

8. AGE: Years 90 Months 9 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Care of home

11. Industry or business _____
MOTHER FATHER { 12. Name Suel Hilton _____
13. Birthplace don't no _____
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Hilton _____
15. Birthplace don't no _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature F. E. Wells Jr
(b) Address Cantwell Missouri

17. (a) Burial (b) Date thereof Dec 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation S.O.O.F. St. Francois

18. (a) Signature of funeral director C. J. Boyce
(b) Address Dealog Missouri

19. (a) 1/9/41 (b) W. B. Luckenbach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Cantwell, Mo.
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9
year 1940 hour 3 Pm minute _____ M.
21. I hereby certify that I attended the deceased from Feb
1939, to Dec 9, 1940
that I last saw her alive on Dec 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 3 days
Due to Infirmitiy of age
Due to _____

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

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? no

23. Signature W. Zuppan (M. D. or other) DO.
Address Flat River, Mo. Date signed 1/11/41

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

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.

FORM 1 X1911

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..... *C. J. Boyler*.....
Licensed Embalmer No..... *1671*.....
P. O. Address..... *Dunlap 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.