No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1173

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 133

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lakeside Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 30 yrs -

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1661 Madison 8
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME William Taylor Wells

3. (b) If veteran, name war Mo

3. (c) Social Security No. Mo

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Wells

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Nov 4 - 1883 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
57	2	4	____ hr. ____ min.

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

10. Usual occupation Dry. Gds. Merchant

11. Industry or business Self

MOTHER FATHER
12. Name Wm Taylor Wells
13. Birthplace Way. Va - (City, town, or county) (State or foreign country)
14. Maiden name Nancy E. Rader
15. Birthplace Ark (City, town, or county) (State or foreign country)

16. (a) Informant Ella Wells
(b) Address 1661 Madison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan - 10 - 41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Moriah Cem

18. (a) Signature of funeral director Mrs C L Foster
(b) Address 918 Brooklyn

19. (a) Jan 9 1941 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8th year 1941 hour 6.45 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 7th, 1941, to Jan 8th, 1941, that I last saw alive on Jan 8th 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure, terminal.

Due to Lobar pneumonia Nov 29th to Jan 8th
Nursing

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature Alfred E. Linville (M.D. or other)
Address 612 Chambers Bldg Date signed 1-8-41
K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Me

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

working under my personal supervision.

Signed J. Clair Shippard

Licensed Embalmer No. 4179

P. O. Address K. C. Mo.

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

If this body is not embalmed, fact should be so stated above.