

FILED MAY 9 1941

State File No. _____

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. 166

1. PLACE OF DEATH:

- (a) County Cape Girardeau
 (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 hrs
(Specify whether _____)
 In this community 12 years
years, months or days

3. (a) PRINT FULL NAME Ibbie wells

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife James wells 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased Sept 27 1892
(Month) (Day) (Year)

8. AGE: Years 48 Months 6 Days 26th If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

- MOTHER FATHER { 12. Name James Sinnerman
 13. Birthplace Judeauia Mo
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant John wells
 (b) Address Diablot 7th
 17. (a) Burial (b) Date thereof 4-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lecterville Mo
 18. (a) Signature of funeral director Shabough Fun. Home
 (b) Address Cape Girardeau Mo
 19. (a) 4-21-41 (b) J. M. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Cape Girardeau
 (c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
 (d) Street No. 817 Illinois
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21 - 41
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Fr Skull Cerebral Excitation Fr Mandible + Middle H. Duration _____
 Due to _____

Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 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) Accident
 (b) Date of occurrence 4-21-41
 (c) Where did injury occur? near Blountney Mo
(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) (e) Means of injury Auto
 23. Signature D. B. Elrod (M. D. or other) _____
 Address Cape Girardeau Mo Date signed _____

17026
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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.....

W. H. E. T. S.

Licensed Embalmer No.....

3568

P. O. Address.....

*Cape Girardeau
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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14127
Registrar's No. 144

Registration District No. 125

Primary Registration District No. 309

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 Elvie Wells

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

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

8. AGE: Years 48 Months 6 Days 24 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____ (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 21
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fr skull
Cerebral Laceration Fr
mandible

Due to Collision with
car.

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) acc.

(b) Date of occurrence 4/21/41

(c) Where did injury occur? Near Blumeyer Capels No
(City or town) _____ (County) _____ (State) _____

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

While at work _____ (Specify type of place) _____ (e) Means of injury auto, acc

23. Signature D. Reed (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-14127