

No. 2
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FILED JUL 7 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20797**

Registrar's No. **2327**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 1/2 days**
(Specify whether)
 In this community **19 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3415 Paseo**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Mrs. Nina Audrey Wells**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **6** day **16** year **1941**
 hour _____ minute **7:52** A. M.

3. (b) If veteran, name war _____
 3. (c) Social Security No. **493-14-8170**

21. I hereby certify that I attended the deceased from
6-8-41, 19____, to **6-16-41**, 19____;
 that I last saw her alive on **6-16-41**, 19____;
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **married**

Immediate cause of death **Generalized Peritonitis**
 Due to **Appendectomy**
 Due to **Ulcer**

6. (b) Name of husband or wife **Bert Wells, Jr.**
 6. (c) Age of husband or wife if alive **27** years
 7. Birth date of deceased **Oct. 2 1913**
(Month) (Day) (Year)

Other conditions **Ulcer**
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations **Ulcer**
 Of autopsy _____

8. AGE: Years **27** Months **8** Days **14**
 If less than one day hr. _____ min. _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

10. Usual occupation **Housewife**
 11. Industry or business _____

12. Name **Squire James Pine**

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

14. Maiden name **Glenna Young**
 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bert Wells, Jr.**
 (b) Address **3415 Paseo, K. C. Mo.**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) **burial** (b) Date thereof **June 19, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Washington Cem.**

(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? _____

18. (a) Signature of funeral director **R. V. Lindsey & Sons**
3811 Broadway
 (b) Address **3811 Broadway**

While at work _____ (Specify type of place)
 (c) Means of injury **3**
23. Signature **R. V. Lindsey** (M. D. or other)
 Address **3811 Broadway** Date signed _____

19. (a) **6/18/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

048
3
8

121

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

Leon D. Stewart

Licensed Embalmer No. *4177*

P. O. Address *Kansas City, 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. 20797

Registrar's No. 2327

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution:
St. Joe Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: *In hospital or institution* (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME

Mrs. Rena Audrey Wells

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex *FE*

5. Color or race.....

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

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

Months

Days

If less than one day

27

hr. 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.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

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

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

(b) Address.....

19. (a).....

(Date received local registrar) *7/10/41*

(b).....

M. M. Corowe
(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. *3415* *Forest*
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Month *6* day *16*
year..... 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.....

Generalized Peritonitis
Appendectomy & suspension of uterus

Due to.....

Due to.....
Polypus uterus

Other conditions.....
(Include pregnancy within 6 months of death)

Major findings:
Of operations..... *12/1*

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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

