

FILED OCT 8 1942

State File No. \_\_\_\_\_

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 171

88  
366

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

1. PLACE OF DEATH: Randolph  
 (a) County Moberly  
 (b) City or town. Moberly  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Wabash Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 weeks  
(Specify whether)  
 In this community 23 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Randolph  
 (c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 504 Roberts St.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME LEANDER KLINE WELLS  
 (b) If veteran, name war None  
 (c) Social Security No. 702-05-8167

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept. day 20<sup>th</sup>  
 year 1942 hour 2 minute 40 P.M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married 1 divorced married  
 (b) Name of husband or wife Pearl Wells  
 (c) Age of husband or wife if alive 44 years  
 7. Birth date of deceased June-10-1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 10 42, 19\_\_\_\_ to Sept 20, 19\_\_\_\_  
 that I last saw him alive on Sept 20, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE: Years 51 Months 3 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Acute myocardial failure  
 Due to Emphysema 2 mo  
 Due to Appendectomy 12 1/2

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

Other conditions Perforated appendix  
(Include pregnancy within 3 months of death)

10. Usual occupation Train Dispatcher

11. Industry or business Wabash RR

Major findings: Of operations Perforated appendix  
Perforated appendix  
 Of autopsy Perforated appendix  
 Underline the cause to which death should be charged statistically.

12. Name Leander Gideon Wells  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Kline  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L. K. Wells  
 (b) Address 504 Roberts St. Moberly MO

17. (a) Burial (b) Date there Sept. 23 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

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)

18. (a) Signature of funeral director Snow Funeral Home  
 (b) Address Moberly MO

19. (a) Sept. 21-42 (b) Arma Kaul  
(Date received local registrar) (Registrar's signature)

23. Signature Raymond J. Kasper (M. D. or other)  
 Address Wabash Hosp. Moberly Date signed 9-21-42

OCT 19 1942

RECEIVED

District Health Officer No. 10

District File Number 10-42-1 **MAR 20 1944**

Date Filed OCT 7 1942

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 R. M. Cater

Licensed Embalmer No. 4117

P. O. Address Moberly 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.