

LED MAY 5 1943

Registration District No. _____

Primary Registration District No. 2007

Registrar's No. 110

1. PLACE OF DEATH: Butler
 (a) County: _____
 (b) City or town: Poplar Bluff, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Poplar Bluff Hosp. I.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: two days
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo. (b) County: Butler
 (c) City or town: Butler Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME: PHILLIP DONALD WELLS
 3. (b) If veteran, _____ name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 4
 year 1943 hour 6 minute 45 a.m.

4. Sex: M
 5. Color or race: W
 6. (a) Single, widowed, married, divorced: 2
 6. (b) Name of husband or wife: _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb 10 1941
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-3, 1943 to 4-4, 1943
 that I last saw him alive on 4-3, 1943
 and that death occurred on the date and hour stated above.

8. AGE: Years 2 Months 2 Days 25
 If less than one day _____ hr. _____ min.

Immediate cause of death: Broncho-pneumonia, bilateral
 Duration: Unknown

9. Birthplace: Butler Mo
 (City, town, or county) (State or foreign country)

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 107

10. Usual occupation _____
 11. Industry or business _____
 12. Name: Sam Wells
 13. Birthplace: Butler Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name: Allen Jones
 15. Birthplace: Butler Mo
 (City, town, or county) (State or foreign country)

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

16. (a) Informant: Sam Wells
 (b) Address: Butler Mo
 17. (a) _____ (b) Date thereof: 4-6-43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: New Hope Cemetery
 18. (a) Signature of funeral director: loyd Russell
 (b) Address: Biggs Park
 19. (a) 4-6-43 (b) Belle Turner
 (Date received local registrar) (Registrar's signature)

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) _____ (e) Means of injury _____
 While at work? _____
 23. Signature: J. W. Tronda (M. D. or other) _____
 Address: Poplar Bluff, Mo Date signed 4-5-43

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 543-577

Date Filed 5-4-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.