

S. No. 2
1-9-4-41
5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42854
State File No. _____
Registrar's No. 1083

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: SPRINGFIELD MO.
(c) Name of hospital or institution: 228 E. THOMAN /
(d) Length of stay: _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: GREENE 39
(c) City or town: SPRINGFIELD MO. 2
(d) Street No. 228 E. THOMAN (If rural, give location) 6
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: RITA LORENE WELLS
(b) If veteran, name war: NONE
(c) Social Security No.: unk.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DEC day 29 year 1943 hour 5 minute 45 A. M.
21. I hereby certify that I attended the deceased from 2-15-1943 to 12-29-1943
that I last saw her alive on 12-16-1943 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: SINGLE
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: XX years
7. Birth date of deceased: MAY 14 1916 (Month) (Day) (Year)

Immediate cause of death: Tuberculosis (Pulmonary)
Due to _____
Due to _____
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 27 Months 7 Days 15 If less than one day hr. min.

9. Birthplace: Canoll Co. Ark (City, town, or county) (State or foreign country)

10. Usual occupation: Folder

11. Industry or business: Clothing mfg Co.

12. Name: David W. Wells

13. Birthplace: Canoll Co. Ark (City, town, or county) (State or foreign country)

14. Maiden name: Hattie E. Dickens (City, town, or county) (State or foreign country)

15. Birthplace: Canoll Co. Ark (City, town, or county) (State or foreign country)

16. (a) Informant: Hattie E. Wells

(b) Address: SPRINGFIELD MO.

17. (a) (b) Date thereof: Jan 1-1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Roberson Funeral Home

18. (a) Signature of funeral director: J. W. Higgins & Co. (b) Address: SPRINGFIELD MO.

19. (a) 12-31-43 (b) 57 W. 9th St. (Date received local registrar) (Registrar's signature)

1381
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature: [Signature] (M. D. or other) _____
Address: Springfield Mo. Date signed: 12-30-43

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

79
2
6

984

(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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *J. B. Klingner*.....
Licensed Embalmer No..... *335-8*.....
P. O. Address..... *Springfield, 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.