

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

2  
43  
39  
35497

FILED MAR 13 1944

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 123 State File No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 8111/2 W. 2nd St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Life time  
years, months or days

3. (a) PRINT FULL NAME William W. Wells

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

3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Mrs. Wells 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Dec 2 1889  
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Relief Filling Station Operator

11. Industry or business \_\_\_\_\_

12. Name Robert Wells

13. Birthplace no record  
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mae Wells

(b) Address 8111/2 W. 2nd St

17. (a) burial (b) Date thereof 2 29 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stark Memorial

18. (a) Signature of funeral director Pharmacia

(b) Address 421 E. Wall St

19. (a) 2-28-44 (b) Johnnie M. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper

(c) City or town Joplin  
(If outside city or town limits, write "RURAL")

(d) Street No. 8111/2 W. 2nd  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28th  
year 1944 hour 12 minute 2 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him live on about 1 mo. ago, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberc. 25 yrs  
in toxic.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 138

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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)

Means of injury o

23. Signature R. M. Jones (M. D. or other) \_\_\_\_\_  
Address Joplin Mo Date signed 3/28/44

4.7-2-186

MAR 1 3 1944

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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 Del A. Karabie

Licensed Embalmer No. 3590

P. O. Address Joplin 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.