V. S. No. 2
00M—8-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

19666

State File No.

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 223

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

18541

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 yrs State
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Audrain 14
(c) City or town Laddonia 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME JAMES A. WELLS

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex male
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife dont know
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Mar (Month) 2 (Day) 1863 (Year)

8. AGE: Years 83 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)
10. Usual occupation laborer
11. Industry or business farm

FATHER
12. Name James A. Wells Sr
13. Birthplace dont know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name dont know
15. Birthplace dont know (City, town, or county) (State or foreign country)

16. (a) Informant Records
(b) Address State Hospital #1
17. (a) Remove (Burial, cremation, or removal) (b) Date thereof June 22, 46 (Month) (Day) (Year)
(c) Place: burial or cremation Laddonia Mo
18. (a) Signature of funeral director Earl T Pruitt
(b) Address Mexico Mo
19. (a) June 22-46 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22 year 1946 hour 2 minute 40 a M.
21. I hereby certify that I attended the deceased from June 11, 1946 to June 22, 1946 that I last saw him alive on June 21, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar pneumonia	11d
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 108	
Of autopsy none held	

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature J Caldwell (M. D. or other) MD
Address Fulton Mo Date signed 6/22/46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 7-8-46

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 Carl E. Prestel

Licensed Embalmer No. 3189

P. O. Address Mexico 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.