

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED DEC 2 1946

Registration District No. ~~371~~ 371

Primary Registration District No. 6261

State File No. 39458

Registrar's No. 19

1. PLACE OF DEATH:
 (a) County Webster
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rogersville R.F.D. #3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 24 Years

2. USUAL RESIDENCE OF DECEASED:
Webster
 (a) State Missouri (b) County Cass
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No Rogersville R.F.D. #3
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James E. Wells
 3. (b) If veteran, name was Spanish American No. No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month November day 16
 year 1946 hour 2 minute 25 A.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Margaret
 6. (c) Age of husband or wife if alive 35 1/2 years

21. I hereby certify that I attended the deceased from 11/14 1946 to 11/15 1946
 that I last saw him alive on 11/15 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>9</u>	<u>2</u>	_____ hr. _____ min.

Immediate cause of death:
Chronic Nephritis
 Due to mitral regurg.

Duration
years

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

Due to Cerebral Hemorrhage
 Other conditions 5 days
(Include pregnancy within 3 months of death)

PHYSICIAN

10. Usual occupation Farmer
 11. Industry or business Farming
 12. Name Steve Wells
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
(City, town, or county) (State or foreign country)
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Margaret Wells
 (b) Address Rogersville R.F.D. #3
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20-1946
(Month) (Day) (Year)
 (c) Place: burial or cremation National Cemetery

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) Manner of injury _____

18. (a) Signature of funeral director J. W. Klingner & Co.
Springfield, Mo.
 (b) Address
 19. (a) 11-21-46 (Date received local registrar)
 (b) Lester D. Good (Registrar's signature)

23. Signature O. A. Focht (M. D. or other)
 Address Stefford Mo Date signed 11/19/46

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

1/2
0
0

38272

342

RECEIVED

District Health Officer No. 6

District File Number 1146-1168

Date Filed NOV 29 1946

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

Ogle Stone Jr.

Licensed Embalmer No.

4176

P. O. Address

Springfield

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.