

U. S. No. 2
 FORM 5-43
 Rev. 5-17-39
 No. 1 X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **28720**
 Registrar's No. **81**

FILED AUG 12 1947
 Registration District No. **277**

Primary Registration District No. **6022**

1. PLACE OF DEATH:
 (a) County **Ray**
 (b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R.F.D.#1, Richmond, Missouri
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **None**
(Specify whether years, months or days)
 In this community **45 Years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Ray**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **R.F.D.#1, Richmond, Mo.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Robert Wells**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Margaret Wells**
 6. (c) Age of husband or wife if alive **72** years
 7. Birth date of deceased **October 26, 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	8	27	hr. min.

9. Birthplace **Bloomfield, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Well Driller**

11. Industry or business _____

MOTHER } 12. Name **Unknown**
 FATHER } " "
 13. Birthplace _____
 14. Maiden name **Unknown**
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Margaret Wells**
 (b) Address **R.F.D.#1, Richmond, Missouri**

17. (a) **Burial** (b) Date thereof: **7/25/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Antioch Cemetery**

18. (a) Signature of funeral director **Quest-Life F. Home**
 (b) Address **Richmond, Missouri**

19. (a) **July 28, 47** (b) **M. A. Jackson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **23rd**
 year **1947** hour **2** minute **25** P. M.

21. I hereby certify that I attended the deceased from **July 15**
 19**47**, to **July 23**, 19**47**;
 that I last saw him alive on **July 23**, 19**47**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage (Rpt)**
 Due to **Hypertension**
 Duration **15 days**
 years

Due to **Arteriosclerosis**

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

Major findings:
 Of operations _____
 Of autopsy _____
 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 **M. A. Jackson** M.D.
 Address **Pola Mo** Date signed **7-25-47**

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-18-47

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 *George W. Hale*

Licensed Embalmer No. 4060

P. O. Address *Baltimore, Md.*

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.