

No. 2
12-45
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38500

State File No.

Registrar's No.

FILED NOV 24 1947

Registration District No.

149

Primary Registration District No.

1002

4607

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 min.
In this community 5 min.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3300 W. Parkwood
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Baby Wells

3. (b) If veteran, name war

no

3. (c) Social Security No.

none

4. Sex male 5. Color or race w

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased 10 - 22 - 1947
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
			hr. <u>5 min.</u>

9. Birthplace Kansas City - Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business

MOTHER FATHER

12. Name Sam Jay Wells

13. Birthplace Tulsa Oklahoma
(City, town, or county) (State or foreign country)

14. Maiden name Mary Elizabeth Rice

15. Birthplace Parsons Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Ms Mary Wells

(b) Address 3300 W. Parkwood K.C. Kan

17. (a) cremation (b) Date thereof Oct 22 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hospital

18. (a) Signature of funeral director Research Hosp.
(b) Address R. C. no.

19. (a) 11-3-47 (b) Thereldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1947 hour 12 minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct.
22, 1947 to 10-22, 1947.
that I last saw alive on 10-22, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to 5 1/2 month Gestation
Prematurity
Duration

Other conditions ³
(Include pregnancy within 3 months of death)
Major findings: 159

Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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

23. Signature Don Carlos Guppy (M. D. or other)
Address 717 Prog Med. Date signed 10/24/47

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.