

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

State File No. **23709**
Registrar's No. **3001**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3001</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>2 Yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		48 3 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) <u>504 W. 14 St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Julia</u>		b. (Middle) <u>Belle</u>		c. (Last) <u>Wells</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 8 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 24 1879</u>	
9. AGE (in years last birthday) <u>70</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Rueben Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ann McCorkle</u>		14. NAME OF HUSBAND OR WIFE <u>John A. Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John A. Wells Kansas City, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rupture of aneurysm of abdominal aorta (arteriosclerotic)</u>							
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4</u> , 19 <u>49</u> , to <u>July 8</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>49</u> , and that death occurred at <u>12:15P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title)				23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u>		23c. DATE SIGNED <u>7-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 10 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Missouri City</u>		24d. LOCATION (City, town, or county) (State) <u>Missouri City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>7-9-49</u>		REGISTRAR'S SIGNATURE <u>Heraldine Holm</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs C.L. Forster Kansas City, Missouri</u>			

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

Dr. P. Thompson

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *K. C., 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.