

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39418

State File No. \_\_\_\_\_

318

1003

Registrar's No. 10519

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>860</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place) <b>5 minutes</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital of LMD</b>				e. STREET ADDRESS (If rural, give location) <b>6309 Lucille Ave</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Edgar B. Wells</b>		b. (Middle) _____		c. (Last) <b>7</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 6, 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 13, 1872</b>		9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teacher</b>		11. BIRTHPLACE (State or foreign country) <b>Aurora Ont. Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13a. FATHER'S NAME <b>John Wells</b>		13b. MOTHER'S MAIDEN NAME <b>Melissa Blandin</b>		14. NAME OF HUSBAND OR WIFE <b>Fannie L. Wells</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <b>Mrs. Fannie L. Wells 6309 Lucille Ave</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute myocardial infarction</b>  ANTECEDENT CAUSES <b>Hypertensive cardiovascular disease</b> 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.				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
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) <b>920</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4:20!</b>			
22. I hereby certify that I attended the deceased from <b>Dec. 6, 1949</b> , to <b>Dec. 6, 1949</b> , that I last saw the deceased alive on <b>Dec. 6, 1949</b> and that death occurred at <b>9:30 A.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>F.R. Bradley</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>Barnes Hospital,</b>		23c. DATE SIGNED <b>12/6/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-9-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>DEC 7</b>		REGISTRAR'S SIGNATURE <b>J. B. Sauter</b>		25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <b>Math. Hermann &amp; Son, Inc. 2161 E. Fair Av</b>			

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis, 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.