

FILED JAN 3 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41296
5746

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town or township) KANSAS CITY		c. CITY OR TOWN Hickman Mills	
c. LENGTH OF STAY (in this place) 18 YEARS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 7000	
d. FULL NAME OF HOSPITAL OR INSTITUTION HAZEL WOOD NURSING HOME		STREET ADDRESS GREGORY HEIGHTS ADDITION 8217 EAST 72ND STREET	

3. NAME OF DECEASED (Type or Print) MARY	a. (First)	b. (Middle) LUCINDA	c. (Last) WELLS	4. DATE OF DEATH (Month) (Day) (Year) DECEMBER-12-1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE-6-1884	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EYE-MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY ROCK ISLAND R.R.	11. BIRTHPLACE (City and State or Foreign Country) MERCER COUNTY, MISSOURI U. S. A.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME MARION WELLS	13b. MOTHER'S MAIDEN NAME MARTHA ALLEY	14. NAME OF HUSBAND OR WIFE MARY L. WELLS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. MARY L. WELLS	ADDRESS 8217 E. 72ND ST. HICKMAN MILLS MO
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular accident	30 min.	
ANTECEDENT CAUSES	DUE TO (b) Generalized arteriosclerotic cordib. vascular disease		8 years
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Diabetes mellitus		10 years
II. OTHER SIGNIFICANT CONDITIONS	Generalized debility - debilitation		
Conditions contributing to the death but not related to the disease or condition causing death.	*smaller severity		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from July 15, 1954, to Dec 12, 1954, that I last saw the deceased alive on Dec 9, 1954, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE Robert R. Russell	(Degree or title) M.D.	23b. ADDRESS Canton, Mo.	23c. DATE SIGNED Dec 13, 1954
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24a. BURIAL CREMATION (REMOVAL) (Specify) BURIAL	24b. DATE DEC-16-1954	24c. NAME OF CEMETERY OR CREMATORY EARLY CEMETERY	24d. LOCATION (City, town, or county) (State) MERCER MISSOURI
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DATE REC'D BY LOCAL REG. 12-15-54	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE A. H. Newcomb	ADDRESS 1281 BRUSH CREEK Kansas City, Mo.
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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.....
Signature of Student Embalmer

Signed *Edward M. Stone*.....

Licensed Embalmer No. *444*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.