

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30188**

BIRTH NO. _____ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **3015** Registrar's No. **96**

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town or township) Cameron		c. CITY OR TOWN St. Joseph	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 1 day		e. STREET ADDRESS (If rural, give location) 8501 Grant St.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Cameron Community Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) DANIEL	b. (Middle) RAY	c. (Last) WELLS	4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1956
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married	8. DATE OF BIRTH Dec. 17, 1952	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Hershel Wells	13b. MOTHER'S MAIDEN NAME Alice Bird	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Hershel Wells ADDRESS 6501 Grant St. City
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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, asthenia, 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) circulatory failure		1 1/2 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) medullary paralysis DUE TO (c) basilar skull fracture		1/2 hour 8 hours
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. accidental crushing of skull			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 9/108 46	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Lithrop Clinton Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 18 56 9Pm.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Tomahawk dropped & crushed skull
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22. I hereby certify that I attended the deceased from **9-18**, 19**56**, to **9-19**, 19**56**, that I last saw the deceased alive on **9-19**, 19**56**, and that death occurred at **1:48** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chad Warren D.O.	23b. ADDRESS Lithrop, Mo.	23c. DATE SIGNED 9-19-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-20-1956	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. 9-29-56	REGISTRAR'S SIGNATURE Francis D Crawford	5. FUNERAL DIRECTOR'S SIGNATURE John Stump ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

5310

9561 6 T 10M1

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.....
John E. Rupp

Licensed Embalmer No. *398*

P. O. Address *St. Joseph*

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.