

XC-KUNOWN

SL-15217

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42766  
State File No. ....  
Registrar's No. **10760**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	d. Is 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) <b>2 DAYS</b>		e. STREET ADDRESS (If rural, give location) <b>1903 A CORA.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>35 VET ADM HOSPITAL</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>OTTO</b>		b. (Middle) <b>B</b>	
c. (Last) <b>WELLS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11-6-57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Sept. 6, 1910</b>
9. AGE (In years last birthday) <b>47</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLOTHES PRESSER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>LAKE VILLAGE, ARKANSAS</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>BEN WELLS</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH ?</b>	14. NAME OF HUSBAND OR WIFE <b>ALBERTA WELLS</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW 2</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>VA. HOSP RECORDS. 915 N GRAND ST LOUIS MO</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ARTERIOLOSCLEROTIC RENAL DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTÉCEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		_____ <b>446x</b>	
II. OTHER SIGNIFICANT CONDITIONS		_____	
Conditions contributing to the death but not related to the disease or condition causing death.		<b>ASPIRATION OF GASTRIC CONTENTS</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) <b>NONE</b>		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)		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 <b>11-4-57</b> , 19___, to <b>11-6-57</b> , 19___, that I last saw the deceased alive on <b>11-6-57</b> , 19___, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
23a. SIGNATURE <b>M. D. Westphaelinger</b>		23b. ADDRESS <b>VAH. ST. LOUIS MO.</b>	
23c. DATE SIGNED <b>11-7-57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11-12-57</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>N. F. WESTPHELINGER, M. D. International Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 12 57</b>		REGISTRAR'S SIGNATURE <b>Charles J. Gates</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Gates</b>		ADDRESS <b>4107 Finney Ave.</b>	

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..... *Gupton Swan*  
Licensed Embalmer No. *4580*

P. O. Address..... *4107 Fern*

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.