

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-003993  
STATE FILE NUMBER

FILED APR 7 1958

Registration District No.

42

Primary Registration District No.

1000

Registrar's No.

344

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS <b>101 South Noyes Blvd</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BERNICE</b> Middle Last <b>WELLS</b>			4. DATE OF DEATH Month <b>March</b> Day <b>22</b> , Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1907</b>	9. AGE (In years at birthday) <b>50</b>	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Benton County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>J.H. Holloway</b>		13b. MOTHER'S MAIDEN NAME <b>Chessie Rice</b>		14. NAME OF HUSBAND OR WIFE <b>W.S. 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 Address <b>W.S. Wells St. Joseph, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) <b>Carcinoma of uterus</b>					<b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>1</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>1955</b> to <b>1958</b> and last saw her <sup>her</sup> alive on <b>21 March 1958</b> Death occurred at <b>1:15</b> <b>A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>William B. McDonald M.D. D</b>			22b. ADDRESS <b>301 N. 8th St, St. Joseph, Mo.</b>		22c. DATE SIGNED <b>22 March 1958</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 24, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>	
24. FUNERAL DIRECTOR <b>Meurhoffer, Thomas</b> by <b>Eck</b>		ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 24, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Sandell</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. All diseases in Part I must be causally related.

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  .....  
Licensed Embalmer No. ....  
P. O. Address .....

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.