

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040270  
STATE FILE NUMBER  
3162

FILED NOV 19 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</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>V A HOSPITAL</b>		Length of stay in 1b <b>13 years</b>	d. STREET ADDRESS (If outside, give location) <b>1806 1/2 FOREST</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle Last <b>WELLS</b>			4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 12, 1888</b>	9. AGE (In years (birthday) <b>70</b> ) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City employee</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Lon Hill, Louisiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Elijah Wells</b>	13b. MOTHER'S MAIDEN NAME <b>Cindy Burroughs</b>	14. NAME OF HUSBAND OR WIFE <b>Cora Wells</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>433-07-8134</b>	17. INFORMANT <b>VA Hospital Official Records, K. C. Mo.</b> Address
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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>Renal infarcts; occlusion of superior mesenteric artery</b> DUE TO (b) <b>Atherosclerosis of aorta</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4500</b>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>VA Hospital</b>	COUNTY <b>Kansas</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>October 16, 1958</b> to <b>October 29, 1958</b> Death occurred at <b>2:50 a.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	21b. last saw him alive on _____
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22a. SIGNATURE (Degree or title) <b>E. Foroughi, M.D.</b>	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>10-29-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-3-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fort Leavenworth, Kansas</b>
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24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary, K.C. Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-31-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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(Licensed Embelmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Millard B Perkins*

Licensed Embalmer No. *5013*

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.