

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000371

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 92

300 3
1-57

1. PLACE OF DEATH
a. COUNTY Buchanan

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Inside Limits Yes No

c. CITY OR TOWN St. Joseph 0117 0 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp. D.O.A Length of stay in 1b 17 years

d. STREET ADDRESS (If outside, give location) 5110 Savannah Road Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
LEEMAN DWIGHT WELLS January, 24, 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH Sept. 21, 1901 9. AGE (In years last birthday) 57 yrs. 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) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Cawood, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Samuel Wells 13b. MOTHER'S MAIDEN NAME Hannah Alridge 14. NAME OF HUSBAND OR WIFE Mrs. Elsie Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war # & dates of service) Yes W. W. #1 16. SOCIAL SECURITY NO. 500-07-4896 17. INFORMANT Mrs. Elsie Wells, St. Joseph, Mo. Address 5110 Savannah Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 2 hours
DUE TO (b) Arterio sclerosis not sure
DUE TO (c) Bronchial asthma 11 9
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 241X 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE 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 Jan 24 59 to Jan 24 59 and last saw her alive on Jan 24 - 59 Death occurred at 10:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Colles Rounady MD 22b. ADDRESS 2300 Kirtland Blvd 22c. DATE SIGNED Jan 26 59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE Jan. 27, 1959 23c. NAME OF CEMETERY OR CREMATORY Graves Cemetery 23d. LOCATION (City, town, or county) (State) Guilford, Missouri

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE
St. Mary's Funeral Home St. Joseph, Mo. Jan 26, 1959 Mrs. Clark Goodell

MEDICAL CERTIFICATION
Dr. Collis Rounady
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Local, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph, 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.