

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008230

STATE FILE NUMBER

Registration District No. 377 Primary Registration District No. 6267 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY WEBSTER

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

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

c. CITY OR TOWN 1128 EAKLAND MO Inside Limits Yes No

c. FULL NAME OF HOSPITAL OR INSTITUTION Length of stay in 1b

d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No
2 MI SOUTH WEST

3. NAME OF DECEASED First Middle Last
ROBERT WELLES

4. DATE OF DEATH Month Day Year
FEB 9 1959

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH MAY 15 1872 9. AGE (In years last birthday) 86 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) RET CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) INDIANA 12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME GEORGE WELLES 13b. MOTHER'S MAIDEN NAME REBECCA HAWORTH 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 17. INFORMANT Address
LORENE ODEM EAKLAND MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CIRCULATORY FAILURE

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) CORONARY THROMBOSIS

DUE TO (c) ARTERIO SCLEROSIS

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 NO 4201

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 WORK 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 DID NOT ATTEND - PUBLIC HEALTH OFFICER and last saw him alive on Death occurred at 4:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS Marshallfield, Mo. 22c. DATE SIGNED 2/10/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 2-11-1959 23c. NAME OF CEMETERY OR CREMATORY ORGONIA 23d. LOCATION (City, town, or county) (State) ORGONIA MO.

24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS MARSHFIELD 25. DATE RECD. BY LOCAL REG. FEB 11 1959 26. REGISTRAR'S SIGNATURE [Signature]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 George Stapf

Licensed Embalmer No. 3161

P. O. Address Mrs. Broughton

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.