

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008428  
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 155

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Fayette</u> - 451 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo. Medical</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>108 Clark St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lana</u> Middle <u>Dee</u> Last <u>Wells</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>10</u> IF UNDER 24 HRS. Min.
11. BIRTHPLACE (City and state or country) <u>Fayette, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ronnie L. Wells</u>		13b. MOTHER'S MAIDEN NAME <u>Mary M. Crigler</u>	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ronnie L. Wells</u> Address <u>Fayette Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>50 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>CONGENITAL HEART DISEASE CYANOTIC TRANSPOSED GREAT VESSELS.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) <u>7630</u>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE	
21. I attended the deceased from <u>4-1-59</u> , to <u>4-3-59</u> and last saw her <u>him</u> alive on <u>4-3-59</u> Death occurred at <u>8:45</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>(Ronnie) Van Deussen M.D.</u>		22b. ADDRESS <u>U. of Mo. Medical Center</u>	
22c. DATE SIGNED <u>4-3-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>4/3/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOONESBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONESBORO MISSOURI</u>	
24. FUNERAL DIRECTOR <u>Halphal Carr Fayette Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 4 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Max R E Palmer</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.  
Locust, scarlet, etc. must use only standard nomenclature in item 18. No symptoms with 30 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 *Donald L Roberts* .....

Licensed Embalmer No. *4722* .....

P. O. Address *Fayette 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.