

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013609

FILED MAY 1 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 1866 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lindeman Nursing Home		d. STREET ADDRESS 3527 Main	
3. NAME OF DECEASED (Type or print) First S. Middle DE KALB Last WELLMAN		4. DATE OF DEATH Month April Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Fireman		11. BIRTHPLACE (City and state or country) Boulder, Colorado	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Sylvanus Wellman		13b. MOTHER'S MAIDEN NAME Romelia Towner	14. NAME OF HUSBAND OR WIFE None
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. None	17. INFORMANT Address Mrs. Opal Mc Daniel K. C. 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) Cerebral thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterio sclerosis, cerebral DUE TO (c) 6 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			INTERVAL BETWEEN ONSET AND DEATH 1 day
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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 COUNTY STATE
21. I attended the deceased from apr. 1954 to 4/11/59 and last saw her alive on 4/10/59 Death occurred at 11:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James A. Jarvis (Degree or title)		22b. ADDRESS Kansas City, Mo.	22c. DATE SIGNED 4/13/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 4-13-59	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 4-13-59	26. REGISTRAR'S SIGNATURE Neve Trinchell

James A. Jarvis USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2 <

The Robert Hummel
4640 Highland Avenue

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *K. C. 7*

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.

2 <