

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016891

STATE FILE NUMBER

589

FILED JUN 8 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

|   |                           |   |   |  |   |
|---|---------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Buchanan |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN St. Joseph  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Joseph's Hosp.   |                           | Length of stay in 1b<br>0/11/59   | d. STREET ADDRESS (If outside, give location)<br>813 North 10th   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First MIDDLE Last<br>IDA MAE WELLS   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>June 1, 1959  |  |   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH<br>Oct. 31, 1889   | 9. AGE (In years last birthday)<br>69                            | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife & taxicab Owner  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Missouri  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                              |   |
| 13a. FATHER'S NAME<br>not known   |                           | 13b. MOTHER'S MAIDEN NAME<br>Alice Elizabeth Bernett  |   | 14. NAME OF HUSBAND OR WIFE<br>Lawrence Wells                    |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>500-36-1417  | 17. INFORMANT Address<br>Mrs Nancy Kraman Chicago, Ill.   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RUPTURE MYOCARDIUM<br>DUE TO (b) RECENT MYOCARDIAL INFARCTION<br>DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>4 200 |                           |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>5 M.I.A.<br>1 WK.                                 |
| 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<br>Hour Month, Day, Year<br>a.m. p.m.   |                           |   |   |  |   |
| 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 Death occurred at  |                           | 21. I attended the deceased from 5/31/59 2:05 P.M. to 6/1/59 and last saw her alive on 5/31/59 on the date stated above; and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE (Degree or title)<br>John T. Rogers M.D.   |                           | 22b. ADDRESS<br>307 Highland Dr. Mo.  |   | 22c. DATE SIGNED<br>6/1/59                                       |   |
| 24. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 23b. DATE<br>June 3, 59   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cemetery  | 23d. LOCATION (City, town, or county) (State)<br>Atchison, Kans. |   |
| 24. FUNERAL DIRECTOR<br>H.O. Sidemeyer & Son  |                           | ADDRESS<br>St. Joseph, Mo.  | 25. DATE RECD. BY LOCAL REG.<br>June 2, 1959  | 26. REGISTRAR'S SIGNATURE<br>Mrs. Clara Goodell                  |   |

All diseases in Part I must be causally related.

Dr. John T. Rogers

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*Dr Rogers*

**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 *Robert H. Yapp* .....

Licensed Embalmer No. 3308 .....

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.