

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041324

FILED VS DEC 8 1959

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 141

ENDED

1. PLACE OF DEATH a. COUNTY <b>Pulaski Co</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Waynesville, Mo.</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Crocker, Missouri</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Waynesville Gen. Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>None.</b>
3. NAME OF DECEASED (Type or print) First <b>ROLLA</b> Middle <b>EVANS</b> Last <b>WELLS.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/11/1916</b>
9. AGE (last birthday) <b>43</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Carrier.</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Dixon, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>Thomas H. Wells.</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Ann Humphrey</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Wells.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>Mrs. Mary Wells Crocker, Mo</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia (Secondary)</b> DUE TO (b) <b>Myocardial Heart Failure</b> DUE TO (c) <b>Rheumatic Fever</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>19 yrs.</b> <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>L</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 <b>May 1959</b> <b>7:40 A</b> to <b>Nov. 22, 1959</b> and last saw <sup>her</sup> him alive on <b>Nov. 21, 1959</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John A. Puchowich D.O.</b>		22b. ADDRESS <b>Crocker, Missouri</b>	22c. DATE SIGNED <b>11/23/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crocker Memorial Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Crocker, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Hodges Funeral Home Crocker, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-24-59</b>	26. REGISTRAR'S SIGNATURE <b>Paula Mae Anderson</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 9 1959

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

*Clarence Moore*

Licensed Embalmer No.

*4896*

P. O. Address

*Waynesville*

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.