MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-019609
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4789

FILED JUN 2 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis ~~Hosp.~~
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Luke's Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St Louis
c. CITY OR TOWN: Bridgeton
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 7367 Park Ave
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Preston Middle – Last Wells
4. DATE OF DEATH: Month 5 Day 20 Year 61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-22-1907
9. AGE (last birthday): 53
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): Welder
10b. KIND OF BUSINESS OR INDUSTRY: Public Works
11. BIRTHPLACE (City and state or country): Pope Co. Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James W. Wells
13b. MOTHER'S MAIDEN NAME: Cora Reynolds
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Joe Wells Address: Brookport Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pop mitral Valvulotomy
DUE TO (c) Rheumatic Heart disease.
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410X
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 a.m. p.m. Month, Day, Year
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 4-17-61, to 5-20-61 and last saw ~~her~~ him alive on 5-20-61
Death occurred at 705 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Kenneth N Huey MD
22b. ADDRESS: 5340 Del Mar
22c. DATE SIGNED: 5-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5/22/61
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cem.
23d. LOCATION (City, town, or county): Metropolis (State): Illinois

24. FUNERAL DIRECTOR: Kennedy ADDRESS: Brookport, Ill.
25. DATE REC'D BY LOCAL REG.: MAY 22 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

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_____ Signed Frank Prokopf

Signature of Student Embalmer

Licensed Embalmer No. 4356

P. O. Address St Louis 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.