

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=61-023888**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 29

AMENDED

**FILED JUL 24 1961**

1. PLACE OF DEATH a. COUNTY <b>Andrew</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Savannah</b>		Length of stay in 1b <b>5 years</b>	c. CITY OR TOWN <b>Savannah</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>105 Maple St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>105 Maple</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WELLS</b> Last <b>WELLS</b>			4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1961</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>12/30/1874</b>
9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>McComb, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Benjamin Wells</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>Julia An Colvin</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha Alice</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 <b>Mrs. Bertha Wells, 105 Maple, Savannah, 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>Carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
DUE TO (b) <b>Carcinoma of the Sigmoid Colon</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)			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.)	
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>1-9-55</b> to <b>7-4-61</b> and last saw him alive on <b>7-4-61</b> Death occurred at <b>11:55 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Tilbert B. Kelley MD</i>		22b. ADDRESS <b>Savannah, Mo.</b>	22c. DATE SIGNED <b>7-7-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7/7/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Savannah Mo.</b>
24. FUNERAL DIRECTOR <i>Horton Bowman</i> St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. <b>7-10-61</b>	26. REGISTRAR'S SIGNATURE <i>T. L. ...</i>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

**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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 5610 St. 119

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.