

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3805-61-028696  
STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

AMENDED

FILED AUG 16 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CLAY</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>CLAY</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in lb <u>LIFE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>220 No. WALNUT</u>		d. STREET ADDRESS (If outside, give location) <u>220 No. WALNUT</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
<u>BRYAN J. WELLS Sr.</u>			<u>JULY 29, 1961</u>			

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAM FILTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CLAY COUNTY, Mo</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>CHARLES WELLS</u>	13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE</u>	14. NAME OF HUSBAND OR WIFE <u>ROSE WELLS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>MR. BRYAN J. WELLS JR. K.C. 16. Mo.</u>	Address <u>308 N. WALNUT</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>		<u>30 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardiac vascular disease 15-20 years</u>	
	DUE TO (c) <u>Generalized Arteriosclerosis 15-20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</u>		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 type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from <u>July 29 1961</u> to <u>7-29-61</u> and last saw him alive on <u>July 29 1961</u>
Death occurred at <u>11:55</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>4030 North K.C. Mo</u>	22c. DATE SIGNED <u>7-31-61</u>
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23a. BEHALF OF REMOVAL (Specify) <u>JURIAL</u>	23b. DATE <u>8-1-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EAST SLOPE Cem.</u>	23d. LOCATION (City, town, or county) <u>RIVERSIDE</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S Sons N.K.C., Mo.</u>	ADDRESS <u>7-31-61</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 SHOULD READ  
 ITEM NO.

McCORMICK

**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 *John V. McCormick, Jr.*  
Licensed Embalmer No. 4848

P. O. Address H. B. 17, Iowa

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.