

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-035102

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8774

STATE FILE NUMBER

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 mo.</u>		c. CITY OR TOWN <u>St. Louis</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>Missouri Baptist Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5048a Devonshire</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vernon Wesley Wells</u>				4. DATE OF DEATH Month Day Year <u>September 19, 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>11/20/1905</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Co.</u>		11. BIRTHPLACE (City and state or country) <u>Marshall, Iowa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>John Wesley Wells</u>			13b. MOTHER'S MAIDEN NAME <u>Nettie Patterson</u>			14. NAME OF HUSBAND OR WIFE <u>Mabel Wells</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				17. INFORMANT Address <u>Mabel Wells, 5048a Devonshire</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____			DUE TO (c) <u>4201</u>			
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 checked="" type="checkbox"/> NO <input 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 <u>September 16 1961</u> to <u>Sept 19, 1961</u> and last saw him alive on <u>September 19 1961</u> Death occurred at <u>12:05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>James A. Neukirchner, MD</u>				22b. ADDRESS <u>114 North Juniper St. So.</u>			22c. DATE SIGNED <u>9/20/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) <u>Wyaconda, Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>SEP 21 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

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 William J. Knappe

Licensed Embalmer No. 4052

P. O. Address 4911 Canal St. Jones Ar

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.