

S. No. 2  
M-54  
v. 5-17-39  
P1 X29484

23773

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

JUL 28 1942  
Registration District No.

Primary Registration District No. 6240

Registrar's No. 54

500  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Barry  
(b) City or town Barry R.R. Mo  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community fifty years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barry  
(c) City or town Barry R.R.  
(d) Street No.  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Dock Emmet Welles

3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Pearl Wells  
6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Aug 30 1878  
(Month) (Day) (Year)

8. AGE: Years 63-63 Months 9 Days 0  
If less than one day hr. min.

9. Birthplace Lee County Virg  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name Albert Welles

13. Birthplace unknown Virg  
(City, town, or county) (State or foreign country)

14. Maiden name Rizbeth M. Welles

15. Birthplace unknown Virg  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Pearl Wells  
(b) Address Barry Mo

17. (a) Burial (b) Date thereof July 2 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cassville Cemetery

18. (a) Signature of funeral director W. L. Lippan  
(b) Address Cassville, Mo

19. (a) July 2 1942 (b) Grace Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30 day June  
year 1942 hour 5:30 minute 0 M.

21. I hereby certify that I attended the deceased from  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack  
This man was dead when I saw him.  
Due to Heart attack from  
history of case.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Signature O. S. McCall (M. D. or other) \_\_\_\_\_  
Address Wheaton Mo Date signed 6-28-42

Duration  
Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

1077

RECEIVED

District Health Officer No. 6,

District File Number 742-1039

Date Filed JUL 27 1942

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed John E. Myers  
Licensed Embalmer No. 3220  
P. O. Address Cassville, 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **23773**

Registration District No. **29**

Primary Registration District No. **6240**

Registrar's No. **54**

1. PLACE OF DEATH:

(a) County **Barry**  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community **50 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Dock Emmet Wells**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **June** Day **30** Year **1942** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. (Immediate cause of death)

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive **50** years  
7. Birth date of deceased **any 30** (Month) (Day) (Year)

Duration \_\_\_\_\_

8. AGE: Years **63** Months **9** Days **19** (If less than one day \_\_\_\_\_ min.)

Due to **Mitral Stenosis**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations **92b.**  
Of autopsy \_\_\_\_\_

9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **O S McCall** (M. D. or other) \_\_\_\_\_

Address **Wheaton mo** Date signed **5-26-42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is scattered across the page and cannot be transcribed accurately.]