

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31084

State File No. 320 320  
Registrar's No. 320 320

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>320 320</u>			
1. PLACE OF DEATH a. COUNTY <u>Marion</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST-Elizabeth Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u> d. STREET ADDRESS (If rural, give location) <u>506 Willow</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>M.</u> c. (Last) <u>Wells</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 17-1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 27-1869</u>		9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> IF UNDER 2 HRS. Hours <u>   </u> Min. <u>   </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Griggsville Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Bern. Wells</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Jester</u>			14. NAME OF HUSBAND OR WIFE <u>Ella</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Virginia Turner, 925 Lyon, Hannibal Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH  <u>3.31X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Sept 18 49</u> to <u>Sept 17, 19 49</u> , that I last saw the deceased alive on <u>Sept 17, 1949</u> , and that death occurred at <u>5:52 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>M. J. Collins (M.D.)</u> (Degree or title)				23b. ADDRESS <u>Hannibal Mo</u>		23c. DATE SIGNED <u>Sept 22 49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. Olive Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Marion Mo</u>			
DATE REC'D BY LOCAL REG. <u>9-24-49</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. C. ...</u>		ADDRESS <u>Hannibal Mo</u>			

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

**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 \_\_\_\_\_

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed .....  
Student Embalmer

Signed

*Michael H. O'Donnell*

Licensed Embalmer No. 3246

P. O. Address Humboldt 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.**