

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Pettis

Township _____

or

Village _____

or

City SedaliaRegistration District No. 668Primary Registration District No. 3032File No. 32028Registered No. 267

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Georgette. Wolkey

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

W

SINGLE Married
MARRIED
OR DIVORCED
(Write the word)

DATE OF BIRTH

Nov. 1 1883
(Month) (Day) (Year)

AGE

32 yrs. 0 mos. 0 ds. IF LESS than
1 day, 0 hrs. or 0 min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Shop man

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Mo

PARENTS

NAME OF FATHER

Wolkey

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo

MAIDEN NAME OF MOTHER

Wolkey

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. George Wolkey

(ADDRESS)

Smithton Mo

Filed

Sept 30 1916 Chas. B. Long

REGISTRAR

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

September 27, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 18, 1916, to Sept 27, 1916, that I last saw him alive on Sept 27, 1916, and that death occurred, on the date stated above, at 8:57 p.m. The CAUSE OF DEATH* was as follows:

Hodgkin's Disease
72 B 53 P
(Duration) 53 yrs. 8 mos. 0 ds.

Contributory cause (SECONDARY)

(Signed) W. M. McGinnis M. D.
Sept 29, 1916 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Smithton Mo

DATE OF BURIAL

9-29 1916

UNDERTAKER

W. C. Laughlin

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____ (NO _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____

Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____ (Address) _____, 191____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS