

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

Do not use this space.

1. PLACE OF DEATH

County No. Hawaii
Township White Cloud
City (No.)

Registration District No. 617
Primary Registration District No. 5818

File No. 14233
Registered No. 11
St. Ward

2. FULL NAME Harley Edward Wolf
(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 10 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | **4. COLOR OR RACE** white | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,	
				hrs.	min.
<u>1</u>		<u>0</u>	<u>16</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) Otis Colorado
(STATE OR COUNTRY)

10. NAME OF FATHER Edward Ernest Wolf

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rosedale Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Helen Carpenter Luper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Graham Missouri
(STATE OR COUNTRY)

14. INFORMANT Ollie B. Luper
(Address) Barnard Missouri

15. FILED 4/28 1928 Chas. D. Hundert
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 26 1928

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1928, to April 26, 1928, that I last saw him alive on April 26, 1928, and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
1928

CONTRIBUTORY (SECONDARY) J
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

Did an operation precede death? no DATE OF

Was there an autopsy? no

WHAT TEST CONFIRMED DIAGNOSIS? usual
(Signed) James A. Larnabee M.D.

4/27 1928 (Address) Barnard Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lower Neely Cem. **DATE OF BURIAL** 4/28 1928
20. UNDERTAKER W. D. Campbell **ADDRESS** Barnard

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.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Nodaway Registration District No. 617 File No. _____
 Township White Cloud Primary Registration District No. 3-818 Registered No. 11
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Hauley Edward Wolf
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED 4/28 19 28 Cha H. Humboldt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 26 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alone on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ornithosis pneumonia
Primary
 (duration) yrs. mos. da. _____

CONTRIBUTORY (SECONDARY) 1000W
 (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRAICTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Gas. G. Larabee, M. D.
 , 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

id be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. LIVE A FEE FOR CERTIFICATES UNTIL THEY ARE AS PRESCRIBED BY LAW. REG

SUPPLEMENTARY

5-14233