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

Do not use this space.

1535

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1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 125

City Kansas City (No. St. Lukes Hospital St. Ward)

2. FULL NAME Robert Wolfe

(a) Residence. No. ~~St. Lukes Hospital~~ St., 7 Ward. K. C. Kans
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred R R #5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) Jan. 7 1929

7. AGE: Years 0 — Months 0 — Days 0 — If LESS than 1 day, ___ hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) K. C. Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: John F. Wolfe

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

12. MAIDEN NAME OF MOTHER: Nellie Irene Boyle

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

14. INFORMANT: John F. Wolfe
(Address) R.R. 5 K.C.K.

15. FILED Jan 10, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to Jan 7, 1929, that I last saw him alive on Jan 7, 1929, and that death occurred, on the date stated above, at 10:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxia

1618 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 162 (duration) mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Mgr. G. Hamilton, M. D.

1-8, 1929 (Address) 607 Argyle

*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: Means Cem.

DATE OF BURIAL: Jan. 9 1929

20. UNDERTAKER: H. W. Gates

ADDRESS: K.C.K.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.