

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.

SLP 24 1930

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

Do not use this space.

26453

1. PLACE OF DEATH
County Frank Registration District No. 318
Township Springfield Primary Registration District No. 204
City Springfield (No. Thomas, Robert Hospital) St. _____ Ward)
2. FULL NAME Carl Lee Wolf
(a) Residence. No. 971 N. Conroy 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. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 13 1891
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
39 5 19
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Matthew Hall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ellen Taylor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) mo.
(STATE OR COUNTRY)

14. INFORMANT Matthew Hall
(Address) 971 N. Conroy

15. FILED 8-2 19 30 Loss Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-2 19 30
17. I HEREBY CERTIFY, That I attended deceased from 8-2-30 to 8-2-30, 1930, that I last saw him alive on 8-2-30, 1930, and that death occurred, on the date stated above, at 2:00 am m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
 gunshot wound of chest
suicidal
(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (SECONDARY) TIO
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH no

DID AN OPERATION PRECEDE DEATH? yes DATE OF 8-1-30

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS inquest
(Signed) S. T. Miller M. D.
8-2-30 (Address) Springfield 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 East Lawn DATE OF BURIAL 8-3-30
19

20. UNDERTAKER W. H. Stone ADDRESS Madison

W. J. Starn
1887