

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

Do not use this space.

31268

3735

1. PLACE OF DEATH

County Jackson
Township Yeast
City Kansas City (No. K.C. General Hosp)

Registration District No. 033
Primary Registration District No. 1010

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME George Wolfe

(a) Residence, No. 630 North St. 10 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 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 _____ 1870

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 8 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME Michael Wolfe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Katie Hoffmann

15. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) De W. Clerk
K.C. Gen. Hosp. K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St Marys DATE 9/12/31 19.

19. UNDERTAKER Melody McGilley Fu. Home (ADDRESS) Kansas City Mo.

20. FILED 9-11-31 M. M. Lawrence Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-10 1931

22. I HEREBY CERTIFY, That I attended deceased from 9-1 1931, to 9-10 1931

I last saw him alive on 9-10 1931 Death is said to have occurred on the date stated above, at 8:00 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
93C
99B 93C
Date of onset _____

Other contributory causes of importance: Arteritis

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) P. E. Williams M. D.
(Address) Dept. K.C. Gen. Hosp. K.C. Mo.

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.

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