

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

Do not use this space.

31744

1. PLACE OF DEATH
 County Clark Registration District No. 193
 23 Township Des Moines Primary Registration District No. 3270
 City Charles E. De Wolf (No. _____) St. _____ Ward _____
 2. FULL NAME Charles E. De Wolf
 (a) Residence No. _____ St. _____ Ward Michigan
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 2 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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Chas. De Wolf
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 28, 1883
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
48 | 11 | 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer. 1
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Iowa City, Iowa
 (STATE OR COUNTRY)

10. NAME OF FATHER John De Wolf
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Iowa
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Marion O'Henry
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iowa
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Chas. De Wolf
 (Address) White Cloud Michigan

15. FILED 11/4, 1932 H. F. Kircher
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 26, 1932
 17. I HEREBY CERTIFY, That I attended deceased on
Oct 26, 1932, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 3:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Heart Disease

CONTRIBUTORY (SECONDARY) 95%
 (duration) _____ yrs. _____ mos. _____ ds.
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ (1)
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. M. Riggs, M. D.
11/4, 1932 (Address) Wayland mo.

*State the DISEASE CAUSING DEATH, or if 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 Waterloo Cemetery DATE OF BURIAL 10/28, 1932

20. UNDERTAKER H. F. Kircher ADDRESS Wayland Mo.

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. **LV 2 2 1932**

