

REC'D JUN 8 1939

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

18622
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 393
(c) City SPRINGFIELD (d) Street No. 2109 N. Robberson St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 2109 N. ROBBERSON (If nonresident, give city or town and State)

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 Rose L. Wolf
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 5-18-76
7. AGE YEARS 63 MONTHS 1 DAYS 4 If LESS than 1 day, hrs. per min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Steam Locomotive Engineer
9. Industry or business in which work was done, as saw mill, bank, etc. Frisco R.R. Co.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/9 1939
22. I HEREBY CERTIFY, That I attended deceased from 5/9 1939 to 5/9 1939.
I last saw him alive on 5-9-39 1939. Death is said to have occurred on the date stated above, at 11:58 a.m.
The principal cause of death and related causes of importance were as follows:

Acute dilatation of heart
Date of onset 2/10
Other contributory causes of importance: Pulmonary Congestion

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
13. NAME Wm Wolf
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
15. MAIDEN NAME Phillipine Wolf
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
17. INFORMANT (ADDRESS) Mrs. Irene M. Keith Springfield, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Spring Rain Cem. DATE May 12 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. W. Klougart Springfield, Mo.
20. FILED 5-12 1939 Chas. A. George Local Registrar.

Name of operation none Date of none
What test confirmed diagnosis? clinical as there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no, 1939
Where did injury occur? none
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury none
Nature of injury none
24. Was disease or injury in any way related to occupation of deceased?
If so, specify (Signed) S. F. Feltz, M. D. (Address) Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

95-2-2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Roy A. Lavin

Licensed Embalmer No. *1763*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001 Registered No. 393
(c) City Springfield (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/9 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

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

I last saw h. _____ alive on _____, 19 . Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 1 4

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

acute dilatation of heart
arteriosclerotic chronic
pulmonary congestion
Date of onset _____

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

Other contributory causes of importance _____

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED July 6, 1939 Chas. George Local Registrar

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) S. F. Freeman, M. D.

(Address) Springfield

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Every death certificate should be carefully checked before it is issued. A CE 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.

SUPPLEMENTARY

