

RECEIVED AUG 3 1939

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

26142
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 496
(b) Township 1 Primary Registration District No. 3025 Registered No. 71
(c) City Brookfield (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

Jessie M. Wolfscale
(a) Residence, No. 322 W. Clayton 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 F 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from July 22, 1939 to July 22, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1852 Mar 2

I last saw him alive on July 22, 1939. Death is said to have occurred on the date stated above, at 2 P. m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 4 20

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Amsework
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 75

Date of onset 2 Wks

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

Uremia

FATHER 13. NAME Woodson Beard

Other contributory causes of importance: Chl. Nephritis

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

Year

MOTHER 15. MAIDEN NAME Unknown

Name of operation _____ Date of _____

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

What test confirmed diagnosis? Ch Was there an autopsy? no

17. INFORMANT (ADDRESS) Mattie Gaines

23. If death was due to external causes (violence), fill in also the following:

18. BURIAL, CREMATION, OR REMOVAL PLACE Bucklin Mo DATE July - 25 - 1939

Accident, suicide, or homicide? _____ Date of injury _____, 19____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Tommy G. Gaudin Brookfield Mo

Where did injury occur? _____ (Specify city or town, county, and State)

20. FILED Aug 1 39 Jessie Wolfscale Local Registrar

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? no

If so, specify _____

(Signed) Jessie Wolfscale, M. D.

(Address) Brookfield Mo

HEALTH DEPARTMENT

District Health Officer No. 111

District File Number 839-933

Date Filed AUG 2 1939

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.....

James B Mc Clelland....., Registered Apprentice No. 224
working under my personal supervision.

Signed Homer Bowden.....

Licensed Embalmer No. 3295

P. O. Address Brookfield 9

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.