

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

35570
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. Mo. Meth. Hosp. 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 47 yrs. mos. ds. (f) How long in U.S., if of foreign birth 70 yrs. mos. ds.

2. PRINT FULL NAME WILLIAM A. WOLFF
 (a) Residence, No. 2611 Olive 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

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 Anna Wolff
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 8th. 1862
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 0 14
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Blacksmith C.B.C
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 39

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 22nd. 19 39
 22. I HEREBY CERTIFY, That I attended deceased from Oct. 14 19 39 to Oct. 22 19 39
 I last saw him alive on Oct. 22 19 39. Death is said to have occurred on the date stated above, at 11.35p
 The principal cause of death and related causes of importance were as follows:
Bilateral hypostatic broncho-pneumonia Date of onset 10-16-39
 Other contributory causes of importance:
Fracture of neck of right femur 10-14-39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany 6

FATHER 13. NAME William Wolff 6

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany 6

MOTHER 15. MAIDEN NAME Unknown

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany

17. INFORMANT (ADDRESS) Mrs. Anna Wolff
2611 Olive St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cemetery DATE Oct. 24th., 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC.
1946 Calhoun St. Joseph, Mo.

20. FILED Oct. 24, 1939 St. Joseph, Mo.
Local Registrar

Name of operation none Date of _____
 What test confirmed diagnosis? Lab. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 10/14, 1939
 Where did injury occur? St. Joseph, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Public place
 Manner of injury stripped & fell
 Nature of injury fracture of neck of Rt femur

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Cabray Wortley, M. D.
 (Address) 415 Corby Bldg.

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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1939 10 20 1939

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.