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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35388**
Registrar's No. **814**

Registration District No. **318** Primary Registration District No. **5440**

NOV 12 1940

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(d) Length of stay: In hospital or institution 8 days
In this community 8 days

8. (a) PRINT FULL NAME WOLFE, William
(b) If veteran, name war None
(c) Social Security No. Unknown

4. Sex Male 5. Color or race Indian
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased 3 2 1920

8. AGE: Years Months Days If less than one day
20 " 7 3 hr. min.

9. Birthplace Ravensford, No. Carolina

10. Usual occupation CC Camp

11. Industry or business 9

MOTHER { 12. Name Ward Wolfe
18. Birthplace Unknown Unknown
14. Maiden name Carolina Wayne
15. Birthplace Ravensford, No. Carolina

16. (a) Informant Deceased

(b) Address Removal

17. (a) Removal (b) Date thereof Oct. 5, 1940

(c) Place: burial or cremation Bryson City, N.C.

18. (a) Signature of funeral director G. E. Johnson

(b) Address Springfield, Mo.

19. (a) 10-5-40 (b) W. E. Naudley, M.D.

2. USUAL RESIDENCE OF DECEASED:
(a) State No. Carolina (b) County Swain County
(c) City or town Ravensford
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th
year 1940 hour 9:00 minute 20 A.M.

21. I hereby certify that I attended the deceased from Sept. 27, 1940
to Oct. 5, 1940
that I last saw him alive on October 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis, bilateral, far advanced.

Due to _____
Due to _____
Other conditions _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
Since adm. _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? NO (Specify type of place) _____
(e) Means of injury _____

23. Signature L. M. Rogers, Surgeon (M. D. or other) M.D.

Address Clinical Director, MCFP Date signed 10-5-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Harlow Krabb

Licensed Embalmer No. 4065

P. O. Address Springfield Mo

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