

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.

Registration District No. 498

Primary Registration District No. 5663

Registrar's No. 15

FILED DEC 11 1940

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Rural Buckles Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 44 years (Specify whether _____ years, months or days) 2

3. (a) PRINT FULL NAME William Andrew Wolfkill
3. (b) If veteran, name war World War 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single; widowed, married, divorced.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov - 2 - 1896
(Month) (Day) (Year)

8. AGE: Years 44 Months 0 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Buckles Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name C. C. Wolfkill

13. Birthplace Buckles Mo
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Dunn

15. Birthplace Hick Hill Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Carrie Wolfkill

(b) Address Buckles

17. (a) Burial (b) Date thereof 11, 17, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckles

18. (a) Signature of funeral director Carson James Caldwell

(b) Address Buckles Mo

19. (a) Nov 15 - 1940 (b) J. L. Cantwell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn
(c) City or town Rural Buckles
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15
year 1940 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carbide Acid Poisoning

Due to Suicide

Due to Coronary Vein

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence Nov - 15 - 1940

(c) Where did injury occur? Rural Buckles Linn Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 441 Home
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. H. Lucas (M. D. or other)

Address Carson Linn Mo Date signed 11/15/40

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

MOTHER FATHER

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..... *E. J. Larson*

Licensed Embalmer No. *4037*

P. O. Address..... *Bucklin, 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.