

1. No. 2  
4-13-40  
5-17-39  
PI X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

48020

State File No. \_\_\_\_\_

LEO JAN 13 1941  
Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 348

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

4  
2  
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1. PLACE OF DEATH

(a) County Callaway

(b) City or town Fulton, mo

(c) Name of hospital or institution: State Hospital #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether)

In this community Life  
years, months or days 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Fulton  
(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.

3. (a) PRINT FULL NAME ALFRED BENJAMIN WOLKING

(b) If veteran, name war no

(c) Social Security No. OK no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23  
year 1940 hour 12 minute 50 A.M.

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs. A.S. WOLKING

6. (c) Age of husband or wife if alive OK years

7. Birth date of deceased Nov 20 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 18, 1940  
to Dec 23, 1940  
that I last saw him alive on Dec 22, 1940;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

65 1 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Fracture of base of skull

Due to fall while having epileptic seizure

Due to \_\_\_\_\_

9. Birthplace Drake mo  
(City, town, or county) (State or foreign country)

Other conditions arteriosclerosis w/ by perfusion  
(Include pregnancy within 3 months of death)

10. Usual occupation farmer

Major findings: 10.0  
Of operations \_\_\_\_\_

11. Industry or business chicken raiser

Of autopsy \_\_\_\_\_

12. Name OK

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

14. Maiden name OK

15. Birthplace OK  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital #1 records

(b) Address Fulton, mo

17. (a) Burial (b) Date thereof 12/24/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest Cemetery

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

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

(b) Date of occurrence Dec 18, 1940

(c) Where did injury occur? State Hospital, Fulton, mo  
(City or town) (County) (State)

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

While at work? yes (Specify type of place)

(e) Means of injury fall

18. (a) Signature of funeral director John Wallace

(b) Address Fulton, Missouri

19. (a) 12/24/40 (b) R. N. Crank  
(Date received local registrar) (Registrar's signature)

23. Signature John J. Blaska M.D.  
Address Fulton, mo Date signed 12/23/40

Duration 12/18/40

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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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 James O Mudd  
Licensed Embalmer No. 4152  
P. O. Address Fulton, 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, fact should be so stated above.**