V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 20773

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2303

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3715 E 7th. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 10 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 048 3 8

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3715 E 7th. St. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

**3. (a) PRINT FULL NAME** MADGE E. WOLFE

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex / Female

5. Color or race White

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

6. (b) Name of husband or wife Milton C. Wolfe

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased July (Month) 22 (Day) 1894 (Year)

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 10 | 22 | ____ hr. ____ min. |

9. Birthplace Weston Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Samuel Kirkpatrick
13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hulda Hollied
15. Birthplace Holland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Milton C. Wolfe
(b) Address 3715 E 7th. St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Weston, Missouri

18. (a) Signature of funeral director J F O'Donnell Co
(b) Address 3715 E Broadway

19. (a) 6/16/41 (Date received local registrar) (b) M. M. Crone (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 6-14-41 day
year ____ hour ____ minute 9:30 A.M.

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

Deputy Coro

Immediate cause of death Coronary Thrombosis

Due to Coronary Sclerosis

Due to ____

Other conditions (Include pregnancy within 3 months of death) 9:40 94 W

Major findings:
Of operations ____
Of autopsy ____

Duration

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? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Russell Wolfe (M. D. or other)
Address Kansas Date signed

(Licensed Embalmer's Statement on Reverse Side)

## 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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K C 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.**