

FILLED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3603

30845

Registration District No. 359

Primary Registration District No. 1002

Registrar's No.

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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 weeks
(Specify whether
 In this community 47 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson
 (c) City or town Merriam
(If outside city or town limits, write "RURAL")
 (d) Street No. 5914 Mary Lea Road
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from Jan 17
 1941 to 9/26 1941
 that I last saw him alive on 9/26 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Ampulla of Water, Biliary Pathosis of duodenum
 Duration 1 yr 10 m
 Due to _____
 Due to _____

Other conditions: Lung abscess (right)
(Annotate prominently within 3 months of death)
Spontaneous Pneumo thorax
 Major findings: Same
 Of operations: Same
 Of autopsy: Same
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Carrie Ellen DeWolf

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife George E. DeWolf 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: Feb. 21 1868
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Ottawa Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name James W. Gilges

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

14. Maiden name Leonora Rhyne

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

16. (a) Informant Mrs. W. R. McCamish

(b) Address 1111 North 19th St., K.C.K.

17. (a) Burial (b) Date thereof 9-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Muncie, Leavenworth, Ks.

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 9/28/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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? _____
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature H. O. Cornell MD (M. D. or other) MD
 Address 810 Medical Arts Bldg Date signed 9-27-41

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

MOTHER FATHER

P. J. O'Connell
Med. Arts Body
2-5

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..... *Clarence W. Chiles*

Licensed Embalmer No. *3473*

P. O. Address *6 e 760*

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.