DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 14 1941

Registration District No. 1151

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32714

Primary Registration District No. 4588

Registrar's No. 8

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: FARNFELT
(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 years, months or days)
In this community: 40 years

2. USUAL RESIDENCE OF DEACESED:

(a) State: MISSOURI (b) County: Scott

(c) City or town: FARNFELT
(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: JOHN WOLF

3. (b) If veteran, name war: ____

3. (c) Social Security No.: ____

4. Sex: MALE

5. Color or race: WHITE

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

6. (b) Name of husband or wife: MALINDA CAROLINE WOLF

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

7. Birth date of deceased: Oct (Month) 11 (Day) 1857 (Year)

8. AGE: Years 83 | Months 10 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace: JACKSON COUNTY (City, town, or county) / ILLINOIS (State or foreign country)

10. Usual occupation: FARMING

11. Industry or business: ____

FATHER
12. Name: PHILLIP WOLF
13. Birthplace: / TENN. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: MARGARET LINDSEY
15. Birthplace: / TENN. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Tempa Wolf
(b) Address: Avert Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 14 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Pomona Ill.

18. (a) Signature of funeral director: M. B. Forberg
(b) Address: Cape Girardeau Mo

19. (a) Aug. 14 1941 (Date received local registrar) (b) Paul Bray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11 year 1941 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from July 27, 1941, to Aug 11, 1941, that I last saw him alive on July 27, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis — Duration

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): 93

Major findings: Of operations: ____

Of autopsy: ____

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: Fred W. Parks M.D. (M.D. or other)
Address: Ill Mo Date signed 8-12-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK

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.

Rev. 5-17-39
I X19511

OCT 13 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32714

Registration District No. 1151 Primary Registration District No. 4588 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston (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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Wolf.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Oct (Month) 11 (Day) 1857 (Year)

8. AGE: Years 83 Months 10 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER 12. Name

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

FATHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11-17-41 (Date received local registrar) (b) Paul Bray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day year 1941 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY