

FILED FEB 13, 1942

Registration District No. _____ Primary Registration District No. 604

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

1. PLACE OF DEATH:

(a) County Scott Delos T.

(b) City or town Illmo, Mo.

(c) Name of hospital or institution: Home

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none

In this community 4.5 yrs.

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100

(c) City or town Illmo

(d) Street No. _____

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

If yes, name country ✓

3. (a) PRINT FULL NAME SIDNEY GRANT WOLFF

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 Elizabeth Wolff

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 12/20/1864

(Month) (Day) (Year)

8. AGE: Years 78 Months 15 Days _____

If less than one day _____ hr. _____ min.

9. Birthplace Chambersburg PA. 1

(City, town, or county) (State or foreign country)

10. Usual occupation R.R.

11. Industry or business _____

MOTHER FATHER

12. Name Bernett Wolff

13. Birthplace Chambersburg PA. 1

(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace 9

(City, town, or county) (State or foreign country)

16. (a) Informant Chester B. Wolff

(b) Address Illmo, Mo.

17. (a) Burial (b) Date thereof 1 7 1942

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cap. Gravel Cemetery Illmo, Mo.

18. (a) Signature of funeral director Burlinghoff

(b) Address Illmo, Mo.

19. (a) 1-7-42 (b) S. D. Brown

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4

year 1942 hour 3:50 minute _____ M.

21. I hereby certify that I attended the deceased from 12/2/41

_____ 19 _____ to 1/3/42 19 _____

that I last saw him alive on 1/3/42 19 _____

and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to infectious

Due to _____

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings: none

Of operations none

Of autopsy none

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) no

(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)

Means of injury ✓

23. Signature T. E. Rice M.D. (M. D. or other)

Address Illmo, Mo. Date signed 1/4/42

RECEIVED
District Health Office No. 2,
District File Number 2-42-149
Date Filed 2-10-42

DEC 15 1954

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, fact should be so stated above.