. S. No. 2
0M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17211

State File No.

FILED JUN 7 1943

Registration District No. 9 — Primary Registration District No. 1002 — Registrar's No. 2151

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 Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: 2 days

2. USUAL RESIDENCE OF DECEASED: 999
(a) State: Missouri (b) County: 16
(c) City or town: Shrewsbury (If outside city or town limits, write "RURAL") 0
(d) Street No. 1161 - Kings Highway (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME: Buddy Lloyd Wolfe
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: Male 1
5. Color or race: W
6. (a) Single, widowed, married, divorced: Single 0
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Mar 3 (Month) 1940 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
3	2.	4	hr. min.

9. Birthplace: Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation: none
11. Industry or business:
MOTHER FATHER
12. Name: Dr Lloyd Arnold Wolfe
13. Birthplace: Cameron (City, town, or county) Mo (State or foreign country)
14. Maiden name: Rhoda Myrle Warhage
15. Birthplace: Mo (City, town, or county) (State or foreign country)
16. (a) Informant: Dr Lloyd A Wolfe
(b) Address: Shrewsbury Rd
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-9-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Osborne Mo
18. (a) Signature of funeral director: Wm C. Foster
(b) Address: 918 Brooklyn
19. (a) 5/9/43 (Date received by registrar) (b) M. M. Gross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 7 year: 1943 hour: 4 minute: 35 P.M.
21. I hereby certify that I attended the deceased from May 5, 1943, to May 7, 1943, that I last saw him alive on May 7-5, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Septemia due to streptococcic infection	9 days
Due to: left leg	
Due to: Nail puncture to left leg	
Other conditions (Include pregnancy within 3 months of death): 185	
Major findings: Of operations: 99	
Of autopsy: as above	

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): Acc 042
(b) Date of occurrence: May 1 1943
(c) Where did injury occur? Urich (City or town) Mo (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: 0
23. Signature: H. Connelly Anderson M.D.
Address: 6520 Indep. Ave Date signed: 5-8-43

(Licensed Embalmer's Statement on Reverse Side)

Dr Conley and [illegible]
6520 Independence

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 Theron A. Rehmon

Licensed Embalmer No. 2737

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, fact should be so stated above.