

FILED MAY 18 1943

Registration District No. **251**

Primary Registration District No. **3048**

Registrar's No. **67**

1. PLACE OF DEATH:  
(a) County **Atchison, Missouri**  
(b) City or town **Far Maryville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Francis Hosp. X O**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 days**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Jennie Wolfe**  
3. (b) If veteran, name war  3. (c) Social Security No.

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Wid**  
6. (b) Name of husband or wife **James M. Wolfe** 6. (c) Age of husband or wife if alive  years **24** 1865 (Day) (Year)  
7. Birth date of deceased **Aug 24 1865** (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>73</b>	<b>8</b>	<b>12</b>	hr. min.

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

10. Usual occupation **at Home**

11. Industry or business

12. Name **Lewis Swan**  
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)  
14. Maiden name **Chapman**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ida Bell**  
(b) Address **Tarkio, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-9-43** (Month) (Day) (Year)  
(c) Place: burial or cremation **Tarkio, Mo.**

18. (a) Signature of funeral director **Marie Funeral Home**  
(b) Address **Tarkio, Mo.**

19. (a) **5-6-43** (Date received local registrar) (b) **Marie Cole** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Atchison**  
(c) City or town **Tarkio** (If outside city or town limits, write "RURAL")  
(d) Street No. **2** (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **6** year **1943** hour **7:15 am** M.  
21. I hereby certify that I attended the deceased from **May 2 1943** to **May 6 1943**  
that I last saw her alive on **May 5 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **acute dilatation of heart from an old myocarditis; acute parenchymatous nephritis.**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **37**

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?

While at work?  (Specify type of place) (b) Means of injury  
23. Signature **Chas. A. Bell** (M. D. or other)  
Address **Maryville Mo** Date signed **May 6 1943**

1268

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

MOTHER FATHER

**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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. *M -*

Registration District No. *251*

Primary Registration District No. *3048*

Registrar's No. *64*

1. PLACE OF DEATH:

(a) County *nodaway*  
(b) City or town *marionville*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: *St. Francis Hosp.*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *3 days*  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME *Jennie Wolfe*

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

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

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive

7. Birth date of deceased *Aug 24 1892*  
(Month) (Day) (Year)

8. AGE: Years *77* Months *8* Days *8* If less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

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

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death *acute dilatation of heart from acute myocarditis*

Due to *acute parenchymatous nephritis following a chronic parenchymatous nephritis.*

Other condition (Include pregnancy within 3 months of death)

Major findings: *1318*

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature *Mary Wolfe* (M.D. or other) *Marionville, Mo.* Date of signing *May 31 1943*

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

SUPPLEMENTARY

S-18375