

Registration District No. 135

Primary Registration District No. 5186

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Bosworth Rural Ridge, Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Home of Art Wolfe  
(If not in hospital or institution, write street number or location)

(d) Length of stay: 33 years (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

(d) Street No. 5 miles N W Bosworth  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FLORE OLIVE WOLFE

3. (b) If veteran, name war ✓

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1st  
year 1944 hour 7 minute A.M.

21. I hereby certify that I attended the deceased from Nov 16  
1943 to Jan 1 1944  
that I last saw her alive on Jan 1 1944  
and that death occurred on the date and hour stated above.

4. Sex f

5. Color or race W

6. (a) Single, widowed, married 2 divorced widowed

6. (b) Name of husband or wife William Wolfe

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

7. Birth date of deceased MAY 3rd 1859  
(Month) (Day) (Year)

Immediate cause of death Bronchitis  
recurrent

Duration \_\_\_\_\_

8. AGE: Years 84 Months 7 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Recurrent Bronchitis  
caused by fractured hip

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name John Henry Ross

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

14. Maiden name Nancy Webb

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

16. (a) Informant Art Wolfe

(b) Address Bosworth, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Rock Branch, Twp Mo

18. (a) Signature of funeral director Clifford W. Austin

(b) Address Tina Missouri

19. (a) Jan 6-1944 (b) Ruth Perry Edwards  
(Date received local registrar) (Registrar's signature)

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) (c) Place of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address Bosworth Mo Date signed Jan 3 1944

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 2-2-44

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 Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address: Jena, Missouri

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 135

Primary Registration District No. 5186

Registrar's No. 1

1. PLACE OF DEATH:  
 (a) County Carroll  
 (b) City or town Rural Bidge Jump  
(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 \_\_\_\_\_)  
 In this community \_\_\_\_\_  
years, months or days

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 Flora O. Wolfe  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
 year 1944 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 Bronchitis pneumoniae

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 \_\_\_\_\_ years  
 7. Birth date of deceased May 3 1882  
(Month) (Day) (Year)

Due to Influenza  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 33a  
 Of autopsy \_\_\_\_\_

8. AGE: Years 84 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
 9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 Means of injury \_\_\_\_\_  
 23. Signature W. B. ... (M. D. or other) \_\_\_\_\_  
 Address 1300 North ... Date signed \_\_\_\_\_

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

SUPPLEMENTARY

2436