

FILED APR 6 1944

Primary Registration District No. **3017**

Registrar's No. **58**

27
1
2

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

1. PLACE OF DEATH:

(a) County **Cooper**

(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Dr. Alex Ravenswaay Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Week**
(Specify whether years, months or days)

In this community **All of life.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper**

(c) City or town **Bunceton, Mo. Rural.**
(If outside city or town limits, write "RURAL")

(d) Street No. **Kelly Township**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs. Leola Wolfrum.**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25**
year **1944** hour **5** minute **10 a.m.**

4. Sex **Female** Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Nickolas Wolfrum.**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **October 26** 1887
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 20**
19 **44** to **March 25**, 19 **44**,
that I last saw him alive on **March 25**, 19 **44**,
and that death occurred on the date and hour stated above.

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

56	4	29	hr.	min.
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Immediate cause of death **Coronary Arteriosclerosis**

Due to _____

9. Birthplace **Cooper County, Mo.**
(City, town, or county) (State or foreign country)

Due to **asthma** **3 yrs**

10. Usual occupation **Housewife.**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business **At Home**

Major findings: Of operations **9.4 a**

12. Name **Hollis Hedgepeth.**

Of autopsy _____

13. Birthplace **Cooper County, Mo.**
(City, town, or county) (State or foreign country)

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

14. Maiden name **Nettie Hall.**

15. Birthplace **Cooper County, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nettie Hedgepeth.**

(b) Address **Bunceton, Mo.**

17. (a) **Burial** (b) Date thereof **March 27** 19 **44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Walnut Grove Cem.**

18. (a) Signature of funeral director **Goodman & Bolles**

(b) Address **Boonville, Mo.**

19. (a) **Mar. 29-44** (b) **Dr. Chas. Swap.**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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)

(e) Means of injury **2**

23. Signature **A. B. Custer** (If other than Registrar) **Do.**

Address **Boonville, Mo.** Date signed **2/28/44**

RECEIVED

District Health Office

District No. 100

Date Recd.

4-5-44

APR 12 1944

APR 18 1944

MAY 2 1944

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 G. J. Bolter
Licensed Embalmer No. 3062
P. O. Address Brownsville, 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.