

Registration District No. 149 Primary Registration District No. 1002

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:
1701 East 39th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 Days
years, months or days)

3. (a) PRINT FULL NAME August H. Wolf
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 0 5. Color or race wh 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 11th 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 I _____ hr. _____ min.

9. Birthplace Retired Farmer Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business _____
12. Name Unknown Wolf
13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Stella Rudeen
(b) Address 1701 East 39th St
17. (a) Removal (b) Date thereof Dec-17-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Norborne Missouri
18. (a) Signature of funeral director Eylar Funeral Home
(b) Address Kansas City Mo
19. (a) 12-14-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 47
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1701 East 39th St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 12th
year 1944 hour 8 minute P.M.
21. I hereby certify that I attended the deceased from 11-13
1944 to Dec 12, 1944
that I last saw hm alive on Dec 12, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death What I saw
Due to Cerebral Hemorrhage
Due to _____
Other conditions g d b
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) (a) Means of injury _____
23. Signature Della Johnson (M. D. or other)
Address 1103 W. 11th Date signed 12-14-44

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

Dr Carl Jackson
1103 E. ##/ Armour
We4193

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

Gene E. Heck

Licensed Embalmer No.

4063

P. O. Address

1800 Lenwood Blvd

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.