

V. S. No. 2*
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 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 13 1945

Registration District No. 138

Primary Registration District No. 4220

Registrar's No. 1

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

1. PLACE OF DEATH:
 (a) County Hickory
 (b) City or town Wheatland
 (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 1 (Specify whether
 In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Hickory
 (c) City or town Wheatland (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 Lucinda Cathrine Wolf
 3. (b) If veteran, name war WW 3. (c) Social Security No. 70

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 12
 year 1944 hour 7 minute 05 A. M.
 21. I hereby certify that I attended the deceased from Dec 1
1944, to Dec 12, 1944;
 that I last saw him alive on Dec 12, 1944
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife. 6. (c) Age of husband or wife if
 alive 20 years
 7. Birth date of deceased: March 20 1868
 (Month) (Day) (Year)

Immediate cause of death: Bronchial Pneumonia Duration 12 days

8. AGE: Years 76 Months 8 Days 22 If less than one day
 hr. min.

Due to. Due to. Other conditions: 107
 (Include pregnancy within 3 months of death)
 Major findings: Of operations. Of autopsy.

9. Birthplace: Panora Iowa (City, town, or county) (State or foreign country)
 10. Usual occupation: Housewife

MOTHER FATHER
 11. Industry or business.
 12. Name: Samuel H. Prager
 13. Birthplace: unknown (City, town, or county) (State or foreign country)
 14. Maiden name: Sarah Roberts
 15. Birthplace: unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant: George Wolf
 (b) Address: Wheatland, MO
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-14-44
 (Month) (Day) (Year)
 (c) Place: burial or cremation: Summer Cemetery
 18. (a) Signature of funeral director: Wheatland, MO
 (b) Address:
 19. (a) Jan 30 - 45 (Date received local registrar) (b) Myrtle Carlston (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
 (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?
 (Specify type of place)
 While at work (c) Means of injury
 23. Signature: Carl Bailey (M. D. or other) do
 Address: Heritage St Date signed: Jan 27

DATE 10.7,
1-45-109
2-10-45

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 with the above constitutes grounds for revocation of license.)

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