

S. No. 2
M-5-43
7-5-17-39
P I X36671

FILED JUN 2 1947

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Madawaska
(b) City or town Manchester Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether
In this community 70 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Madawaska
(c) City or town Conception 74
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY WOLFER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1947 hour 12 minute 15 P.M.
21. I hereby certify that I attended the deceased from March
29, 1947, to May 22, 1947;
that I last saw her alive on May 22, 1947;
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race caucasian
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Joseph Wolfer
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased April 21 1868
(Month) (Day) (Year)

Immediate cause of death Hemorrhage & Anemia
Due to Acute monocytic Leukemia

8. AGE: Years 79 Months 1 Days 1
If less than one day _____ hr. _____ min.

Duration 9 days
8 months
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Batesville Ind. Lawrence
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

PHYSICIAN
Major findings: Of operations _____
Of autopsy 74A
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name William Kiper

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

14. Maiden name Wagner

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

16. (a) Informant Katie Kiper

(b) Address Conception Mo

17. (a) Burial (b) Date thereof 5/25/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation St. Columbian Church

18. (a) Signature of General Director F. Adcox Phillips

(b) Address Conception Mo

19. (a) 5/23/47 (b) Deas Holt
(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 _____
(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) Means of injury _____

23. Signature Paul J. Kadwell (M. D. or other) M.D.
Address Conception Mo Date signed 5/23/47

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. 1898

P. O. Address..... Starbuck Md

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.