

S. No. 2
4-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30127**
Registrar's No. **119**

FILED SEP 15 1947
Registration District No. **356**

Primary Registration District No. **4521**

7
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **TEXAS**
(b) City or town **HOUSTON**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 mos.** (Specify whether
In this community **11 mos.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **TEXAS**¹⁰⁷
(c) City or town **HOUSTON** (If outside city or town limits, write "RURAL")⁰
(d) Street No. (If rural, give location)⁹
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **PLINA JANE WOLFE**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JULY** day **24**
year **1947** hour **9** minute **30 A.M.**
21. I hereby certify that I attended the deceased from
..... 19..... 19.....

4. Sex **FEMALE** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JAMES WOLFE**
6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **APRIL 19 1876**
(Month) (Day) (Year)

that I last saw her alive on **July 22** 19**47**
and that death occurred on the date and hour stated above.
Immediate cause of death **Multisclerosis** Duration

8. AGE: Years **71** Months **3** Days **5**
If less than one day hr. min.

Due to **Chronic Yuptitis**
Due to

9. Birthplace **SUCCESS MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business

12. Name **ROBERT WOLFE**

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

14. Maiden name **MINERVA JONES**

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

16. (a) Informant **JAMES WOLFE**

(b) Address **HOUSTON MO**

17. (a) **BURIAL** (b) Date thereof **7-26-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LIBERTY**

18. (a) Signature of funeral director **Saylor V E Elliott**
(b) Address **HOUSTON, MO**

19. (a) **Aug. 7-1947** (b) **Onyette Craig**
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)
Major findings: **1319**
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) **No**

(b) Date of occurrence

(c) Where did injury occur? **None**
(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) (e) Means of injury **0**

23. Signature **Leslie B. Bland** (M. D. or other) **MD**

Address **Lutera, Mo** Date signed **7-25-47**

RECEIVED

District Health Officer No. 5,

District File Number 947502

Date Filed 9-12-47

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 Frank C. Wood

Licensed Embalmer No. 4026

P. O. Address Houston

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.