

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34179
Registrar's No. 179

Registration District No. 179

Primary Registration District No. 4191

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Gasconade
(If outside city or town limits, write "RURAL" and name of township)
(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. 58 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ERNEST CHRIST WOLF

3. (b) If veteran, name war ---- 3. (c) Social Security No. None
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Julia Ann Wolf 6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 12 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Linn Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Trucking

11. Industry or business

12. Name Simon Wolf
13. Birthplace Linn Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Martha Weeks
15. Birthplace Campsville Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Chrissa Wolf
(b) Address Gasconade, Mo.

17. (a) Burial (b) Date thereof 9-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Beckman Cemetery Gasconade, Mo.

18. (a) Signature of funeral director Nugent
(b) Address Hermann Mo

19. (a) 9/5/47 (b) Dr. H. H. H. H. H.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3rd year 1947 hour 12 minute 05 a.m.
21. I hereby certify that I attended the deceased from August 29 1947, to Sept 3 1947,
that I last saw him alive on Sept 2, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident - stroke - apoplexy Duration 6 days
Due to Arterial hypertension 10 yrs
Due to Arteriosclerosis 10 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 43A
Of autopsy None

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) (e) Means of injury

23. Signature Carroll T. Shaw, M.D. (M. D. or other)
Address Hermann, Mo Date signed 9-4-47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9
District File Number
OCT 16 1947
Date Filed

OCT 17 1947

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.....
Chas. N. Pope

Licensed Embalmer No. *2552*

P. O. Address. *Hermann, 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.