

FILED NOV 12 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36829

State File No. _____

Registration District No. 381

Primary Registration District No. 45-73-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Simpson Hospital
(If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Milan, Mo
(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 James David Wolfe

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 18 47
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 12 hr. min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Max Porter Wolfe
13. Birthplace Milan Mo
(City, town, or county) (State or foreign country)
14. Maiden name Helen Alberta Corn
15. Birthplace Milan Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Max Wolfe

(b) Address Milan

17. (a) Buried (b) Date thereof 9-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cadbury Cemetery

18. (a) Signature of funeral director Thompson

(b) Address Milan Mo

19. (a) Oct. 13 - 1947 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18 year 1947 hour 8 minute 45 PM

21. I hereby certify that I attended the deceased from Sept 18 to Sept 18, 1947
that I last saw him alive on Sept 18, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital debility
Due to Premature birth

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 157

Of autopsy _____

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) (r) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address [Signature] Date signed 9-19-47

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

RECEIVED

District Health Officer No. 1

District File Number 11-47-155

Date Filed NOV. 1. 1. 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

Lucas C. Dwyer

Licensed Embalmer No. 3792

P. O. Address. Melan 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.