

FILED NOV 1 1948

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 902

1. PLACE OF DEATH:

(a) County **OSAGE**

(b) City or town **South Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **OZARK OSTEOPATHIC HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)

In this community **2 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **George Elbert Wolf**

3. (b) If veteran, name war _____

3. (c) Social Security No. **# ?**

4. Sex **male**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **Cecil Wolf**

6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **June 19 - 1894**
(Month) (Day) (Year)

8. AGE: Years **54** Months **3** Days **26**
If less than one day hr. min.

9. Birthplace **Atlanta** **Mebr.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Telephone operator**

11. Industry or business _____

12. Name **John E. Wolf**

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

14. Maiden name **Catherine Frazer**

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

16. (a) Informant **wife**

(b) Address **Wheatland, Mo.**

17. (a) **Buried** (b) Date thereof **10-17-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Summer B. Cem.**

18. (a) Signature of funeral director **Robert Hallaway**

(b) Address **Wheatland, Mo.**

19. (a) **10-15-48** (b) **W.E. Hurdley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Wickroy**
(If outside city or town limits, write "RURAL")

(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? **No** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **15th**
year **1948** hour **11** minute **P.M.**

21. I hereby certify that I attended the deceased from **10-13 - 1948** to **10-15 - 1948**

that I last saw him alive on **10-15 - 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **respiratory failure** Duration

Due to **Typhoid due to obstruction of the esophageal duct**

Due to **chronic cholecystitis with cholelithiasis**

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

PHYSICIAN

Major findings: **Empyema of gallbladder and obstruction of esophageal duct due to gallstone 126**

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) _____

(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? _____

23. Signature **Deland E. Utzig** (Specify type of place) (e) Means of injury **2**
Address **200 E. Main St.** (City or town) (County) (State)
Date signed **10-15-48**

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

8761 LAON

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 Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield

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.